Provider Manual

Alameda Alliance for Health
Medi-Cal & Alliance Group Care

August 2020

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Part 1. Alliance Services

Section 1: Introduction

Welcome to Alameda Alliance for Health (Alliance)

Thank you for joining the Alliance provider network! This manual is intended to provide you with the information needed to navigate our health plan and to assist you with offering the best possible care to our Alliance members.

ABOUT THE ALLIANCE

The Alliance is a public, not-for-profit health plan offering high quality managed care to Alameda County residents. We offer two lines of business, Medi-Cal and In Home Supportive Services (IHSS) program, also known as Alliance Group Care.

OUR MISSION, VISION, AND VALUES

The mission of the Alliance is to strive to improve the quality of life of our members and people throughout our diverse community by collaborating with our provider partners in delivering high quality, accessible and affordable health care services. As participants of the safety-net system, we recognize and seek to collaboratively address social determinants of health as we proudly serve Alameda County.

The vision of the Alliance is that we will be the most valued and respected managed care health plan in the state of California.

Our Values (TRACK)

- **Teamwork**: We participate actively, remove barriers to effective collaboration and interact as a winning team.
- **Respect**: We are courteous to others, embrace diversity and strive to create a positive work environment.
- **Accountability**: We take ownership of tasks and responsibilities and maintain a high level of work quality.
- **Commitment & Compassion**: We collaborate with our providers and community partners to improve the wellbeing of our members, focus on quality in all we do and act as good stewards of resources.
- **Knowledge & Innovation**: We seek to understand and find better ways to help our members, providers and community partners.

The Provider Manual

This Provider Manual describes your responsibility as a provider to our members, and is intended as a resource to help you provide them with the best possible care.

The Alliance requires that contracted practitioners, medical groups, providers, hospitals, ancillary providers, and other non-hospital facilities, together referred to as "Provider" or "Providers," fulfill the relevant specified responsibilities described in this Provider Manual.

If you have any questions about the Alliance, our practices, or our members, please feel free to contract our Provider Services Department at **1.510.747.4510**.

Getting Involved

Provider involvement helps us improve services for our members and providers.

WAYS TO PARTICIPATE:

Health Care Quality Committee (HCQC): HCQC meets quarterly. The Alliance Providers are encouraged to participate in the HCQC and its peer subcommittees. HCQC and other subcommittee members are paid a stipend. For more information, please call the Alliance Credentialing Department at **1.510.373.5677**.

Peer Review & Credentialing Committee (PRCC): PRCC meets monthly to review new provider applications, re-credentialing information, and peer review issues on contracted providers.

The Alliance Provider Manual: The Alliance communicates with providers through this manual and periodic updates. Provider suggestions have been incorporated in this manual. Feedback is always helpful in keeping the manual as up-to-date as possible. To share any ideas or comments, please call the Alliance Provider Services Department at **1.510.747.4510**.

The Alliance Provider Updates Bulletin: The Alliance periodically distributes provider letters, newsletters, memos, and updates with additional information to keep you informed. If you haven't received these provider communications, or if you have ideas for topics that you would like to see covered, please call the Alliance Provider Services Department at **1.510.747.4510**.

Provider Training Sessions: The Alliance conducts training sessions throughout the year for providers and their staff. If you or your staff are interested, please call the Alliance Provider Services Department at **1.510.747.4510**.

Pharmacy & Therapeutics (P&T) Committee: The P&T committee meets quarterly to review the drug formulary, and make changes to the authorization review criteria. For more information, please call the Alliance Pharmacy Services Department at **1.510.747.4541**.

Department	Phone Number	Address	Website
Alameda Alliance for Health	Phone Number: **1.510.747.4500** Toll-Free: **1.877.371.2222**	1240 South Loop Road Alameda, CA 94502	**www.alamedaalliance.org**
Alliance Case & Disease Management (CMDM)	Toll-Free: **1.877.251.9612**	1240 South Loop Road Alameda, CA 94502	**www.alamedaalliance.org**
Alliance Compliance Department	Toll-Free: **1.855.747.2234**	1240 South Loop Road Alameda, CA 94502	**www.alamedaalliance.org**
Alliance Eligibility Line	Phone Number: **1.510.747.4505**	1240 South Loop Road Alameda, CA 94502	**www.alamedaalliance.org**
Alliance Grievance and Appeals (G&A) Department	Phone Number: **1.510.747.4567** Fax: **1.855.891.7258**	1240 South Loop Road Alameda, CA 94502	To file a Grievance online, please visit: **www.alamedaalliance.org**
Alliance Health Programs	Phone Number: **1.510.747.4577**	1240 South Loop Road Alameda, CA 94502	**www.alamedaalliance.org/live-healthy**
Alliance Member Services Department	Phone Number: **1.510.747.4567** Toll-Free: **1.877.932.2738** People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**	1240 South Loop Road Alameda, CA 94502	**www.alamedaalliance.org/contact-us** Email: **memberservices@alamedaalliance.org**
Alliance Pharmacy Services Department	Phone Number: **1.510.747.4541** 24-Hour Service: **1.855.508.1713**	1240 South Loop Road Alameda, CA 94502	**www.alamedaalliance.org**

Department	Phone Number	Address	Website
Alliance Provider Services Department	Phone Number: **1.510.747.4510** Fax: **1.855.891.7257**	1240 South Loop Road Alameda, CA 94502	**www.alamedalliance.org/providers** Email: **providerservices@alamedaalliance.org**
Alliance Utilization Management & Authorizations	Phone Number: **1.510.747.4540** Fax: **1.877.747.4507**	1240 South Loop Road Alameda, CA 94502	**www.alamedaalliance.org**
24-Hour Interpreter Hotline (for interpreters by phone*): International Effectiveness Center	Phone Number: **1.510.809.3986**		**www.alamedaalliance.org**
ACCESS Program Alameda County Behavioral Health Care Services	Toll-Free: **1.800.491.9099**	2000 Embarcadero Cove, Suite 400 Oakland, CA 94606	**www.acbhcs.org**
Advice Nurse Line	Medi-Cal Members: **1.888.433.1876** Group Care Members: **1.855.383.7873**		
Clinical Laboratory Outpatient Services: Quest Diagnostics	Toll-Free: **1.800.288.8008**		**www.questdiagnostics.com**
Dental Services (Group Care): Public Authority	Phone Number: **1.510.577.3551**		**www.acgov.org**

Department	Phone Number	Address	Website
Dental Services (Medi-Cal): Denti-Cal	Toll-Free: **1.800.322.6384** People with speaking impairments (TTY): **1.800.735.2922**		**www.denti-cal.ca.gov**
Durable Medical Equipment Provider: California Home Medical Equipment (CHME)	Toll-Free: **1.800.906.0626**		**www.chme.org**
Mental Health Care Services: Beacon Health Options (Also known as College Health IPA; Subcontracted Behavioral Health Provider for Outpatient Mental Health Services)	Toll-Free: **1.855.856.0577**		**www.beaconhealthstrategies.com**
Transportation Services: Logisticare	Toll-Free: **1.866.791.4158**		**www.alamedaalliance.org**
Vision Services (Group Care): Public Authority	Phone Number: **1.510.577.3551**		**www.acgov.org**
Vision Services (Medi-Cal): March Vision	Toll-Free: **1.844.336.2724**		**www.marchvisioncare.com**

*In person interpreters are available for ASL and complex or highly sensitive appointments.

Please see Requesting Interpreter Services in this manual for details on how to submit a fax request.

Section 2: The Alliance Resources

Alliance Provider Services Department

The Alliance Provider Services Department is your primary link to the Alliance. A quick phone call to an Alliance Provider Relations Representative can answer many of your questions about our policies and procedures.

The Alliance Provider Services Department provides information and support to all Alliance network providers about:

- Access
- Alliance promotional materials
- Authorization status trainings
- Benefits
- Claims/billing status
- Contract issues
- Interpreter services
- Member eligibility
- Office address changes
- PCP assignment
- Peer review
- Provider billing accounts
- Provider bulletins
- Provider credentialing & re-credentialing
- Provider discharges
- Provider network inquires
- Provider portal access
- Site reviews
- Transportation services

Alliance Member Services Department

The Alliance Member Services Department helps manage member needs and concerns. The call center is specifically for members and member related issues. If a member has a question about their care or coverage, please encourage them to call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567**.

The Alliance Member Services Department can assist with:

- Changing a member's assigned primary care provider (PCP)
- Checking the status of a claim
- Checking the status of a prior authorization (PA) request
- Finding an in-network PCP or specialist
- Finding the location of an in-network pharmacy
- Health education materials
- Learning more about plan benefits and services
- Mail order pharmacy information
- Referrals to community resources
- Reporting an issue or file a grievance/appeal
- Requesting a reimbursement for covered drugs or services
- Requesting a replacement ID Card
- Interpreter services
- Scheduling transportation for covered services
- Updating a member's contact information
- Verifying a member's eligibility

The Alliance Member Services Department provides printed materials for member such as our Combined Evidence of Coverage (EOC) and health education resources. Members can also learn more about our services and their coverage on our website at **www.alamedaalliance.org**.

The Alliance Member Services Department representatives can also facilitate communication between members and providers.

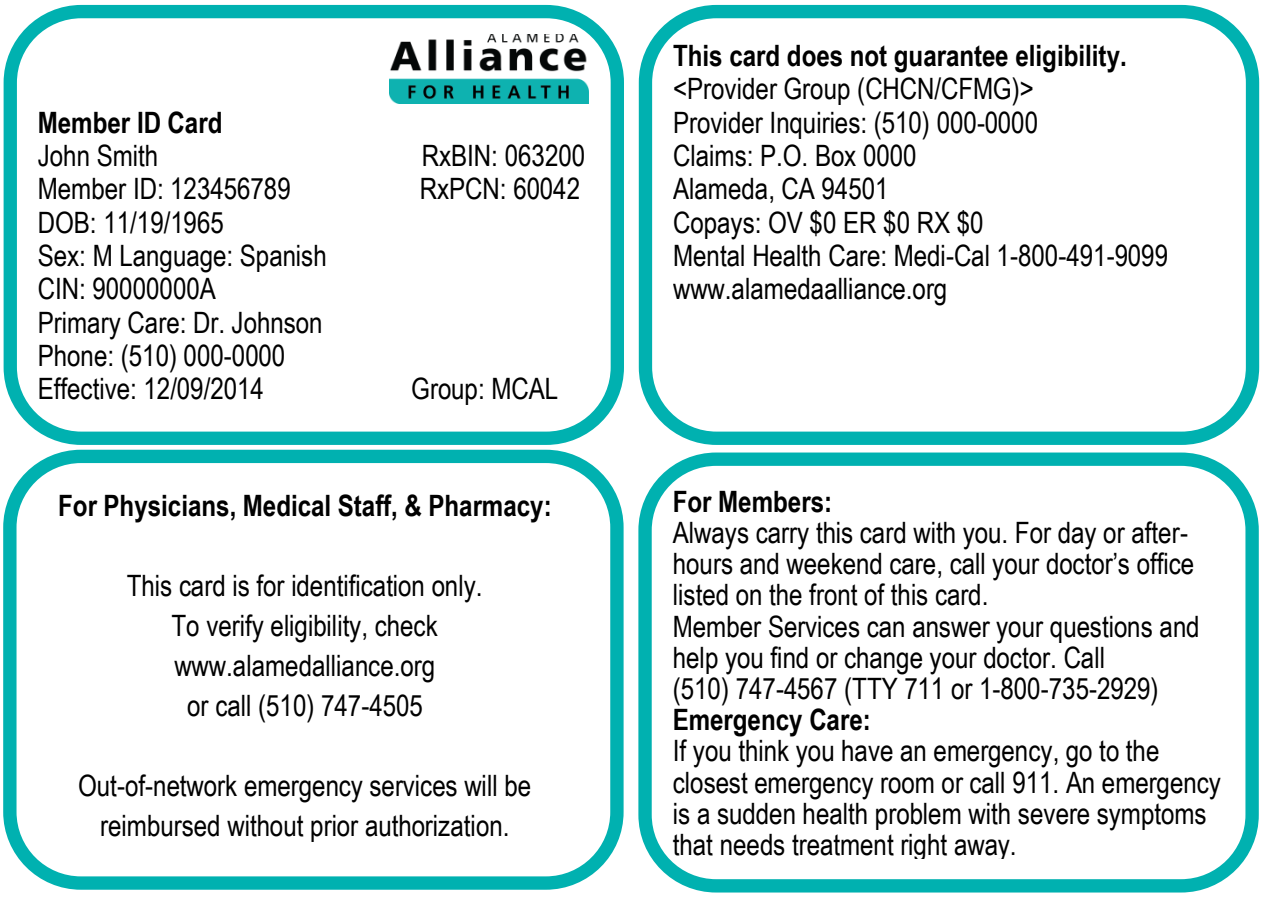
For after-hours eligibility verification, please call the Alliance Eligibility Verification Line at **1.510.747.4505,** 24 hours a day, 7 days a week, or use the Online Provide Portal located on our website at **www.alamedaalliance.org/providers**.

Section 3: Eligibility and PCP Choice

Identifying Alliance Members

Each Alliance member is issued an Alliance member identification (ID) card with a 9-digit member number. Providers can also use the member's Client Identification Number (CIN) to identify members who are Medi-Cal beneficiaries.

The Alliance Medi-Cal Member ID Card



The Alliance Group Care Member ID Card

Member ID Card
Jane Smith
Member ID: 123456789
DOB: 8/19/1958
Sex: F Language: English
CIN: 90000000A
Primary Care: Dr. Johnson
Phone: (510) 000-0000
Effective: 12/09/2014

RxBIN: 003585
RxPCN: 56350

Group: IHSS

This card does not guarantee eligibility.
Provider Inquiries: (510) 000-0000
Claims: P.O. Box 0000
Alameda, CA 94501
Copays: OV $10 ER $35 RX $10G/$15B INPT $100
ACU $5 CHIRO $10
Mental Health Care: IHSS – (855) 856-0577
www.alamedaalliance.org

For Physicians, Medical Staff, & Pharmacy:

This card is for identification only.
To verify eligibility, check
www.alamedalliance.org
or call (510) 747-4505

Out-of-network emergency services will be reimbursed without prior authorization.

For Members:
Always carry this card with you. For day or after-hours and weekend care, call your doctor's office listed on the front of this card.
Member Services can answer your questions and help you find or change your doctor. Call (510) 747-4567 (TTY 711 or 1-800-735-2929)
Emergency Care:
If you think you have an emergency, go to the closest emergency room or call 911. An emergency is a sudden health problem with severe symptoms that needs treatment right away.

Medi-Cal Benefits Identification Card (BIC)

How to Verify Member Eligibility

Your office is responsible for verifying member eligibility and authorization at the time of service.

There are several ways to do this:

- For members who are Medi-Cal beneficiaries:
  Please call the State's Automated Eligibility Verification System (AEVS)
  Toll-Free: **1.800.456.2387**
  www.medi-cal.ca.gov/Eligibility/Login.asp
- For all Alliance line of businesses:
  Please call the Alliance Provider Services Department
  Monday – Friday, 7:30 am – 5 pm
  Phone Number: **1.510.747.4510**.
- Alliance Automated Eligibility Verification Line
  Please have your NPI or TAX ID number available
  24 hours a day, 7 days a week
  Phone Number: **1.510.747.4505**
- Provider Portal: **www.alamedaalliance.org/providers**

Provider Portal Instructions

Online Provider Portal

The Alliance offers contracted providers with access to its interactive website. Through this website you can:

- Check claims status
- Submit/check authorization status
- Verify member eligibility
- View the Alliance drug formulary for all lines of business
- View the Alliance Provider Directory

Information on the website is updated every 24 hours directly from our internal system.

To use the online provider portal you must first obtain a provider account:

- Log on to **www.alamedaalliance.org**, select Provider Portal located at the top right banner, then select the "Create Account" link on the provider portal page.
- For assistance, please contact:
  Alliance Provider Services Department
  Phone Number: **1.510.747.4510**
  Email: **providerservices@alamedaalliance.org**

Selecting a PCP

The Alliance encourages members to participate in their health care by selecting a PCP from the provider network. Members can find a list of PCPs in their Alliance Provider Directories or online at **www.alamedaalliance.org**.

Members can choose a physician who is taking new members from the list of internal medicine, general medicine, family practice, pediatrics and OB-GYNs (women can choose an OB-GYN as their PCP). An Alliance Member Services Representative can help members find a PCP who knows their language or culture, or who is close to where they live or work.

Members can also choose a county or community clinic that is part of the Alliance network as their PCP. All Federally Qualified Health Centers (FQHC) in Alameda County are part of the Alliance Network. Members can go to any FQHC for medical care even if it is not part of the Alliance network.

The Alliance mails members a new ID card with their PCP's name and phone number within **10 business days** to confirm selection (automatic or voluntary). Members may change their PCP by calling the Alliance's Member Services Department.

When a member does not select a PCP in their first month of enrollment, the Alliance will assign a PCP based on member age, language, geographic location, and PCP capacity. A member's choice overrides automatic selection, and a member who has been automatically assigned will be prompted to call the Alliance Member Services Department if they prefer to be assigned to a different PCP.

If the member is enrolled in both Medi-Cal and Medicare, they do not have to select a PCP.

Changing PCPs

The Alliance values member empowerment, and encourages members to find an in-network provider accepting new patients with whom they can build a rewarding primary care relationship. Members can change their PCP for any reason and at any time by calling the Alliance Member Services Department. Changes will be effective the first of the following month when the request is made. In some cases, a member may be added to a practice as long as the Alliance receives the assignment request before the **5th of the month**. If you have questions about a member's eligibility or assignment, please contact the Alliance Provider Services Department.

The Alliance Member Service Department will confirm PCP reassignment and effective date by sending a confirmation letter and a new Alliance ID card with the new PCP's name and phone number within **10 business days** to the member.

If a PCP leaves their practice or is no longer able to see patients for any reason, the Alliance Member Services Department will notify any affected members as soon as possible and assist them in establishing care with another provider.

Section 4: Provider Compliance

The Department of Health Care Services (DHCS) has established guidelines for the Medi-Cal managed care program. Providers should familiarize themselves with these guidelines to avoid sanctions, fines, or suspension of membership.

Travel Time and Distance Standards

DHCS established network adequacy standards to ensure adequate availability and accessibility of services to members. These standards include time and distance standards based on county population density.

For Alameda County, the following standards have been established based on provider type:

- 10 miles or 30 minutes from the member's residence for adult and pediatric PCPs, OB/GYN primary care, and pharmacies.
- 15 miles or 30 minutes from the member's residence for specialty care, hospitals, and adult and pediatric mental health providers.

Alternative access standards may be approved by DHCS.

Alameda Alliance for Health Marketing Materials

PROMOTIONAL MATERIALS

If you are interested in obtaining brochures or promotional materials, please call the Alliance Provider Services Department at **1.510.747.4510**.

Approved Medi-Cal Marketing Methods

As a health care provider, you may:

- Tell your Medi-Cal patients the name of the health plan or plans with which you are affiliated.
- Actively encourage your Medi-Cal patients to seek out and receive information and enrollment material that will help them select a Medi-Cal health care plan for themselves and their family.
- Provide patients with the phone number of the outreach and enrollment or Member Services Departments of the plan(s) with which you are affiliated.
- Provide patients with the toll-free phone number of the DHCS, Health Care Options (HCO) enrollment contractor (**1.800.430.4263**) and inform them of locations and times when they may receive individual or group assistance about selecting a health plan or provider. This number is specifically for beneficiary questions. HCO provides enrollment and disenrollment information, activities, presentations, and problem resolution functions.

Discharging Members

To discharge a member, please call the Alliance Provider Services Department to review the Alliance policy and procedures.

Part 2. Providing Services

Section 5: Primary Care Provider (PCP) Roles and Responsibilities

It is the PCP who acts as the primary case manager to all assigned members. This means the PCP must follow case management protocols as set forth in this section.

PCP Services

CARE MANAGEMENT PROTOCOL

As a PCP in the Alliance network, we ask that you follow care management protocols as set forth in this manual for the following areas:

- Check the rosters posted onto the provider portal monthly to know which members are assigned to you as their PCP.
- Coordinate and direct appropriate care for members by means of an initial diagnosis and treatment, obtaining second opinions as necessary and consultation(s) with contracting specialists.
- Coordinate member discharge planning and referral to long-term care or other services with the hospital and the Alliance.
- Establish procedures to contact members when they miss appointments, require re-scheduling for additional visits, or confirming referrals to a specialist for care.
- Follow-up on referrals made to specialists to assess the results of the care, medication regimen and special treatment, and ensure continuous care.
- Provide a medical history and physical examination as appropriate:
- For new Group Care members: Provide an Initial Health Assessment (IHA) within **120 calendar days** of the member's effective date of enrollment.
- For new Medi-Cal members: Provide an IHA and a Staying Healthy Assessment (SHA) within **120 calendar days** of assignment for patients of all ages.
- Provide the specified scope of services to members.
- Refer, as necessary, certain medically necessary non-emergency hospital specialty services, and diagnostic testing.

STAYING HEALTHY ASSESSMENT

All Alliance members must complete the Staying Healthy Assessment (SHA) or an approved alternate as a part of the IHA and periodically thereafter. The SHA helps identify member's high-risk behaviors, like smoking or poor diet. Members benefit from anticipatory guidance and health education referrals targeted to their questions and current behaviors.

All PCPs must complete a one-time training on how to implement the SHA. The Alliance also offers providers culturally relevant referrals and handouts on Staying Healthy topics in our threshold languages.

For SHA training & resources please visit the Alliance website at **www.alamedaalliance.org/providers/medical-management/staying-healthy-assessment.**

OVERALL GOALS OF CARE MANAGEMENT

The Alliance will assist our PCPs in achieving these overall case management goals:

- Coordinate care of members in order to achieve positive care results.
- Discourage inappropriate use of pharmacy and drug benefits.
- Facilitate patient understanding and use of disease prevention practices and early diagnostic services.
- Provide a structure for physicians to manage services by providing performance data on utilization, cost and quality.
- Provide National Committee for Quality Assurance (NCQA)-compliant Case and Disease Management for members.
- Reduce, where appropriate, the use of emergency services as a source of non-emergency care.

ACCESS STANDARDS FOR PRIMARY CARE PROVIDERS

Please see below for a table detailing required DHCS (Department of Health Care Services), DMHC (Department of Managed Health Care), NCQA, and Alliance required response times.

PRIMARY CARE PHYSICIAN (PCP) APPOINTMENT	
Appointment Type:	**Appointment Within:**
Non-Urgent Appointment	10 Business Days of Request
First OB/GYN Pre-natal Appointment	2 Weeks of Request
Urgent Appointment that *requires* PA	96 Hours of Request
Urgent Appointment that *does not* require PA	48 Hours of Request

SPECIALTY/OTHER APPOINTMENT	
Appointment Type:	**Appointment Within:**
Non-Urgent Appointment with a **Specialist** Physician	15 Business Days of Request
Non-Urgent Appointment with a **Behavioral Health** Provider	10 Business Days of Request
Non-Urgent Appointment with an **Ancillary Service** Provider	15 Business Days of Request
First OB/GYN Pre-natal Appointment	2 Weeks of Request
Urgent Appointment that *requires* PA	96 Hours of Request
Urgent Appointment that *does not* require PA	48 Hours of Request

ALL PROVIDER WAIT TIME/TELEPHONE/LANGUAGE PRACTICES	
Appointment Type:	**Appointment Within:**
In-Office Wait Time	60 Minutes
Call Return Time	1 Business Day
Time to Answer Call	10 Minutes
Telephone Access – Provide coverage 24 hours a day, 7 days a week.	
Telephone Triage and Screening – Wait time not to exceed 30 minutes.	
Emergency Instructions – Ensure proper emergency instructions.	
Language Services – Provide interpreter services 24 hours a day, 7 days a week.	

*** Per DMHC and DHCS Regulations, and NCQA HP Standards and Guidelines**

PA = Prior Authorization

INDIVIDUAL HEALTH ASSESSMENT (IHA)

All new Alliance members must receive an IHA. The IHA consists of a history, review of systems, physical exam, preventive services and the Individual Health Education Behavioral Assessment (IHEBA). For Medi-Cal members, this must be completed within **120 days** of enrollment. During site audits, a PCP's compliance with this standard will be assessed and is part of the yearly performance incentive.

The IHA should consist of an evaluation sufficient to enable the PCP to assess the acute, chronic, and preventive health needs of the member and assume responsibility for effective management of the member's health care service needs.

The required IHEBA can be found at **www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthyassessmentquestionnaires.aspx**

For children, the IHA must consist of the elements found in the most recent periodicity schedule recommended by the American Academy of Pediatrics (AAP). PCPs shall provide preventive health visits for all members less than 21 years of age at times specified by the most recent AAP periodicity schedule. The schedule requires more frequent visits than does the periodicity schedule of the Child Health and Disability Prevention (CHDP) program. The IHA must bring members up to date with all currently recommended preventive services and include all assessment components required by the CHDP for the lower age nearest to the current age of the child.

Codes that qualify for IHA (new member):

Provider	CPT Code	Description
Nursing Home	99304 – 99306	New or Established Patient Comprehensive Nursing Facility Assessments
OB/GYN	59400, 59510, 59610, 59618	Under: • Vaginal Delivery, Antepartum and Postpartum Care Procedures • Under Cesarean Delivery Procedures • Under Delivery Procedures After Previous Cesarean Delivery, • Under Delivery Procedures After Previous Cesarean Delivery
PCP	99201 – 99205	Office or other outpatient visit for the evaluation and management of a **new patient**
PCP	99381-99385	Comprehensive Preventive Visit and management of a **new patient**

Codes that qualify for IHA (previously with the Alliance):

Provider	CPT Code	Description
Nursing Home	99304 – 99306	New or Established Patient Comprehensive Nursing Facility Assessments
OB/GYN	59400, 59510, 59610, 59618	Under: • Vaginal Delivery, Antepartum and Postpartum Care Procedures • Under Cesarean Delivery Procedures • Under Delivery Procedures After Previous Cesarean Delivery, • Under Delivery Procedures After Previous Cesarean Delivery
PCP	99211 – 99215	Office or other outpatient visit for the evaluation and management of an **established patient**
PCP	99391 – 99395	Comprehensive Preventive Visit and management of an **established patient**

Providing Capitated Services to Alliance Group Care Members

SUBMISSION OF CAPITATED SERVICE ENCOUNTERS

PCPs are capitated for their Alliance Group Care members. Capitated services are the PCP's contractual responsibility. These services are covered by the monthly capitation payment. Capitated services **DO NOT** require prior authorization (PA).

PCPs must submit capitated services as claims/encounters to the Alliance with the usual and customary billed charges listed. Reported capitated services will appear along with non-capitated services (fee-for-service claims) in a Remittance Advice to the PCP, although no payment will be associated with such services.

CAPITATED SERVICES TO A NON-ASSIGNED MEMBER

Fee-for-service billing of capitated services is limited to certain situations. Providers who perform a capitated service for an Alliance member who is not assigned to that provider will only be paid for that service on a fee-for-service basis during the following circumstances:

- Annual gynecological examination
- Diagnosis and treatment of a sexually transmitted disease
- Family planning services
- HIV testing and counseling
- Minor consent services

- Prenatal care (a global fee is paid for this type of care, except for specific procedures)
- The member is not assigned to any PCP
- Vaccination Serum, except those covered by the Vaccines for Children (VFC) program

Non-Capitated Services

PCPs may provide services within their scope of practice that are not included in the capitation contract for their assigned members. These services are paid on a fee-for-service basis.

Among the non-capitated services that PCPs can provide to their members on a fee-for-service basis are preventive health care visits and inpatient care services.

Coordination of Care

MENTAL HEALTH SERVICES

With respect to mental health care, the assigned PCP is responsible for:

- A mental health assessment as part of the Initial Health Assessment (IHA).
- Basic assessment of mental disorders.
- Documenting all mental health services provided to members in the medical chart, including referrals to out-of-plan mental health providers.
- Identifying general medical conditions that cause or exacerbate psychological symptoms.
- Ruling out mental disorders due to a general medical condition.
- Ruling out substance-related disorders.

PCPs are also responsible for following these conditions when they occur in the course of treating a medical illness:

- Psychological factors affecting a medical condition.
- Psychological symptoms precipitated by medications being used to treat medical conditions.

As a PCP, you can refer our members to obtain mental health services from a specialty provider for the conditions you are treating.

SUBSTANCE USE TREATMENT SERVICES

Identifying Need for Treatment:

The PCP and prenatal provider have primary responsibility, through screening and examinations, for identification of Alliance members requiring substance use treatment services.

PCPs must also be alert to chemical dependency indicators when treating members for other medical conditions and during required preventive health assessments.

Referrals:
Providers are responsible for directly referring members identified with an alcohol or drug problem to the appropriate treatment program. Providers should counsel and inform members regarding alcohol and drug use and about services available to them. Providers may choose to call the program themselves, or may request that the member contact the program directly. Members may also self-refer to treatment services.

SUBSTANCE USE TREATMENT SERVICES
Medi-Cal Members Alameda County Behavioral Health Plan (ACCESS) helpline Phone Number: **1.510.346.1000** Toll-Free: **1.800.491.9099**
Alliance Group Care Members Beacon Health Options **1.855.856.0577**

PCPs maintain responsibility for basic case management of the Alliance member, including preventive health care and medical services unrelated to the alcohol and drug treatment services. The PCP may also refer the member to the Alliance for case management and substance use screening services.

PCPs should communicate with the alcohol and drug treatment programs in order to coordinate the care of their members in treatment.

Alliance providers should provide medical records to alcohol and drug treatment services, as requested, when members are referred and enter care. Medical records transfer must be in accordance with State law and professional practice standards to ensure confidentiality.

SERVICES FOR MEMBERS WITH DEVELOPMENTAL DISABILITIES
Developmental Disability Referrals:
The Alliance coordinates referrals to the Regional Center of the East Bay (Regional Center) for members with developmental disabilities.

Referral Guidelines:
Providers or family members may refer directly to the Regional Center. The family must make the intake appointment with the Regional Center. Prior authorization (PA) is not required.

Providers must:

- Document the referral to Regional Center in the member's medical record; and
- Provide necessary medical evaluations and obtain written consent prior to releasing any medical information directly to the Regional Center.

Regional Center Location:
The regional center in Alameda County is called the Regional Center of the East Bay.

For more information, please contact:

Regional Center of the East Bay
Creekside Plaza
500 Davis Street, Suite 100
San Leandro, CA 94577
Phone Number: **1.510.618.6100**
Fax: **1.510.678.4100**

PCP Role in Supervision of Mid-Level Clinicians

REQUIREMENTS FOR MID-LEVEL CLINICIANS

PCPs that employ or contract with mid-level clinicians in their practices are responsible for making sure that the mid-level clinicians meet the standards set forth by the clinician's licensing authority. The PCP, as the clinician supervisor, is also responsible for developing the protocols under which the clinician will practice. They must meet certain qualifications and standards in order to be credentialed by the Alliance. This helps ensure quality care for members.

SCOPE OF PRACTICE

A supervising physician must define the scope of practice for each mid-level clinician working in the practice. The scope of practice may vary depending on the skills of the individual clinician, but in all cases must comply with applicable state laws.

CREDENTIALING

Any mid-level clinician that provides care to Alliance members must be credentialed by the Alliance.

DEFINITIONS OF MID-LEVEL CLINICIANS

Mid-level clinicians are non-physician medical practitioners, including:

- Certified Nurse-Midwives
- Nurse Practitioners
- Physician Assistants

Continuing Education: All mid-level clinicians must maintain skills in their field of practice through continuing medical education programs, following the guidelines of their respective certifications. The supervising physician should monitor this process.

Supervision: All mid-level clinicians must practice under supervision of a licensed physician and through following medical policies and protocols established by the physician.

CHARTS

Whenever care is provided by the mid-level clinician, the medical record must be reviewed and co-signed by the supervising physician in accordance with the requirements set forth by the clinician's licensing board. The Alliance will audit for compliance with this standard.

PCP/MID-LEVEL CLINICIAN RATIOS & MEMBER CAPACITY

The number of non-physician medical practitioners who may be supervised by a single PCP is limited to the full-time equivalent of one (1) of the following:

- Four (4) nurse practitioners;
- Three (3) nurse midwives;
- Four (4) physician's assistants; or
- Four (4) of the above individuals in any combination

The ratio is based on each physician, not the number of offices. A PCP, an organized outpatient clinic, or a hospital outpatient department cannot utilize more non-physician medical practitioners than can be supervised within these stated limits.

AFTER-HOURS SERVICE

Mid-level clinicians may participate in the after-hours call network; however, the supervising physician must also be available for consultation when the mid-level is on call.

The provider may also refer members to the Alliance Nurse Advice Line accessible 24 hours a day, 7 days a week:

Medi-Cal Members: **1.888.433.1876**
Group Care Members: **1.855.383.7873**

DISCLOSURE

Members must be informed when a practitioner is a mid-level clinician, and must have the opportunity to request a physician if they wish.

QUALITY AND UTILIZATION MANAGEMENT

Contracted organizations are responsible for adherence to contractual obligations and Alliance quality standards when assuming delegation for Utilization Management (UM) and Quality Improvement (QI). The Alliance maintains responsibility for the overall adherence to quality and utilization standards for Alliance members.

The responsibilities include the following:

- Completion of corrective action plans as required to improve performance.
- Cooperation with Alliance annual audits such as: CMS, DHCS, DMHC and ad hoc state and other regulatory audits.
- Development, enactment, and monitoring of a UM QI Plan that meets contractual requirements and Alliance standards.
- Provide a representative to the Alliance Health Care Quality Committee (HCQC).
- Provision of encounter information and access to medical records for Alliance members.
- Submission of quarterly reports, annual evaluations, and work plans.
- Submission of UM reports based on the delegation agreement.

FACILITY SITE REVIEWS - MONITORING OF FACILITY SITE REVIEWS

DHCS requires that PCPs and high volume specialists that participate in Medi-Cal as the member's primary insurance participate in the site review process and medical record review process. The focus of the site review is to ensure providers' offices meet state standards of cleanliness, patient safety, and medical record keeping. The State regulatory agencies conduct periodic audits of the Alliance's facility site review process. In the event the state elects to conduct a review of their clinic, it is the expectation that the provider will participate.

Each delegate's contract addresses the responsibility for facility site reviews. If the delegated entity is responsible for review of their provider sites, summary reports must be provided to the plan that includes the number of sites reviewed, deficiencies, and any corrective action plans.

POTENTIAL QUALITY ISSUE (PQI)

A PQI is an event or pattern of behavior that may indicate a significant risk to the health and/or well-being of the member(s). It is recognized as a clinical impactful deviation from the standard of care. A PQI involves delivery of clinical care to health plan members. The Alliance analyzes all quality issues. The provider will participate in the investigation of a PQI and provide a written response to a member's allegations or questions about quality of care, as well as copies of medical records, as indicated. The plan contacts the delegated organization when additional information is required and requests assistance when needed to resolve issues.

Section 6: Utilization Management

Overview

The Alliance Utilization Management (UM) Department helps ensure the delivery of high quality, cost-effective healthcare for our members.

The Alliance UM Department serves to accomplish the following goals:

- Ensure that members receive the appropriate quantity and quality of healthcare service(s).
- Ensure that service(s) is delivered at the appropriate time.
- Ensure that the care setting in which the service(s) is delivered is consistent with the medical needs of the member.

The Alliance UM Department decisions are based only on the existence of coverage and appropriateness of care and service. The Alliance does not reward or incentivize practitioners or other individuals for issuing denials of coverage, service, or care. There are no financial incentives for the Alliance UM Department to make decisions that would result in underutilization.

SCOPE OF UM REVIEWS

The Alliance UM Department includes appropriately licensed healthcare professionals to make decisions on provider requests for authorization of services. Authorization decisions are based on eligibility, evidence of coverage, and medical necessity. The Alliance only allows a licensed physician to deny or modify requests for authorization of health care services for reasons of medical necessity.

The Alliance uses a variety of sources to assist in making determinations for care.

The Alliance applies the following policies and/or guidelines:

- Evidenced-based clinical guidelines
- External specialist review
- Alameda Alliance Policy and Procedures for Utilization Management review
- MCG® clinical guidelines (Milliman Care Guidelines)
- Medi-Cal Policy Guidelines and All Plan Letters
- Member's Evidence of Coverage (benefit coverage)

All decisions to modify or deny authorization requests are made by an Alliance Medical Director.

COMMUNICATION AND AVAILABILITY OF UM STAFF TO MEMBERS AND PRACTITIONERS

Peer-to-Peer Discussions

During the course of a utilization review, Alliance Medical Directors are available for peer-to-peer discussions with physicians to support evidenced-based care for our members.

Please Note: an adverse review determination cannot be overturned as a result of the discussion. If an adverse determination still needs to be overturned, the requesting physician will need to follow-up with filing an appeal.

Outpatient (Ambulatory) Services

The Alliance provides covered medical benefits for outpatient (ambulatory) services.

These services include, but are not limited to:

- Chiropractic
- Podiatry
- Rehabilitative and habilitative (therapy) services and devices:
    - Acupuncture
    - Audiology
    - Occupational therapy
    - Speech therapy

For a list of services and authorization requirements, please refer to the *Alameda Alliance for Health Referral and Prior Authorization (PA) Grid for Medical Benefits for Directly Contracted Providers* at **www.alamedaalliance.org**.

Authorizations Requirements

The Alliance requires contracted providers to obtain authorization before the rendering of services.

The following services require authorization for payment:

- All out-of-network services
- Certain radiology, nuclear medicine, and outpatient services and procedures
- Elective inpatient admissions
- Emergency inpatient admissions
- Skilled nursing/rehabilitation admissions

A complete list of service types and procedures requiring authorizations is available at **www.alamedaalliance.org**.

Claims may not be reimbursed if a rendering provider does not receive an authorization approval from the Alliance or one of our delegated partners before rendering services.

The Alliance will only accept Prior Authorization Request (PAR) form, from the treating provider who determined medical necessity for the requested services or procedure. The treating provider is defined as the PCP or specialty clinician that is currently providing care to the member. This includes attending clinicians at a hospital or skilled nursing facility responsible for the member's discharge planning.

NOTIFICATION REQUIREMENTS FOR ACUTE INPATIENT CARE

Contracted facilities must notify the Alliance within **24 hours** of an acute admission. Non-contracted facilities must notify the Alliance as soon as the member's medical condition has been stabilized per California Health and Safety Code Section 1261.8.

All facilities, contracted and non-contracted, must notify the Alliance within **24 hours** of a change in the level of care or discharge from facility.

Upon request, facilities must submit clinical information to the Alliance UM Department by the end of the next business day from the time of the request.

Admission notifications should be faxed to the Alliance UM Department at **1.855.313.6306**. Clinical information can be faxed to **1.855.891.7409**.

Notifications and clinical notes received outside of the above timeframes may result in a denial of the authorization for service and payment.

PROCESS FOR REQUESTING AUTHORIZATION

Unless otherwise indicated, the information provided in this section applies to both contracted and non-contracted providers providing care for an Alliance member assigned to a PCP. Providers are expected to adhere to the process below.

ELECTRONIC SUBMISSION OF AUTHORIZATION REQUESTS

Providers can complete electronic submission of authorization requests by using the Alliance Provider Portal.

Login to the Alliance Provider Portal using Google Chrome and follow these steps:

Step 1: Click on Submit Authorizations under Authorization quick link.
Step 2: Click on "select a form" and choose appropriate drop down:
- Inpatient Authorization (elective procedures only)
- Outpatient Authorization

Step 3: Enter all required fields as directed in this section.
Step 4: Attach medical records to avoid further delay of review or possible denial of services
Step 5: Click submit request once you are ready to submit.

Providers can obtain a PAR form, from the Alliance through any of the following:

- Alliance Provider Services Department: **1.510.747.4510**

- Alliance UM Department: **1.510.747.4540**
- Online: **www.alamedaalliance.org**
  - Click on the link for 'Provider Portal'
  - After you sign in, you will be able to download the form
- Online: **www.alamedaalliance.org/providers/medical-management**

PRIOR AUTHORIZATION (PA) SUBMISSION

Confirm member eligibility with the Alliance:

- Phone Number: **1.510.747.4505**
- Online: www.**alamedaalliance.org**
  - Select 'Provider Portal – check member eligibility'
  - Select an Alliance participating provider.
- Online: **www.alamedaalliance.org**
  - Select 'Provider Portal – Check the Provider Directory'
- Complete all items on the PA request form or as indicated on the Alliance Provider Portal for the requested service.
- Follow separate processes for Durable Medical Equipment (DME) and Prescription Drug Prior Authorizations. Please see below for additional instructions on submitting authorizations for these other services.
- To ensure timely processing, please indicate whether the request is "Urgent", "Routine" or "Retro" on the PA request.
- Submit the PA request form to the Alliance UM Department through one of the following methods:

  Mail: **Alameda Alliance for Health**
  Medical Services Department
  1240 South Loop Road
  Alameda, CA 94502
  Phone: **1.510.747.4540** (does not require form)
  Fax: **1.877.747.4507**

Please Note: Always retain a copy of the completed PA request in the patient medical record.

CONCURRENT AUTHORIZATION SUBMISSION

1. Confirm member eligibility with the Alliance:
   - Phone Number: **1.510.747.4505**
   - Online: **www.alamedaalliance.org**
     - Select 'Provider Portal – check member eligibility"
2. Fax hospital face sheet and census report and all relevant clinical information to **1.855.313.6306**

3. Fax changes to level of care and daily updated clinical information to **1.855.891.7409**

AUTHORIZATION NOTIFICATION OF DETERMINATIONS DECISIONS

An authorization number, along with any quantity and date limits, will be given for all authorizations, regardless of determination status.

Notification is provided within **24 hours** of the review determination. For PA requests, both members and requesting providers are notified. For concurrent inpatient requests, the requesting facility is always notified. Group Care members will receive a notification if the request is denied.

Providers are notified electronically. Members who receive notifications will be mailed a letter.

Members with questions about their notification, or need language assistance may call:

Alliance Member Services Department:
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

To request a copy of the criteria used in the review, providers may contact:

Alliance Authorization Department
Phone Number: **1.510.747.4540**
Fax: **1.877.747.4507**

Provider confidentiality will be maintained regarding releasing criteria related to a specific case.

AUTHORIZATION REVIEW TIMELINESS STANDARDS

The Alliance processes authorization requests in a timely manner and in accordance with regulatory requirements.

The Alliance will make a determination status within the following timeframes:

Request Type	Medi-Cal	Group Care
Urgent	72 hours	72 hours
Routine	5 business days	5 business days
Concurrent	24 hours	24 hours

When there is insufficient information to support a determination decision, the request will be deferred for an additional **14 calendar days** from the initial date the authorization request was received while additional information is gathered from the requesting provider. The Alliance will notify the provider and the enrollee, in writing, that a decision cannot be made within the required timeframe, and specify the information needed. The Alliance will specify the anticipated date on which a decision may be rendered in accordance with regulatory time frames. If the provider has not submitted the requested medical information by the stated deadline, the request may be denied.

A request for an elective (non-urgent) surgery or treatment submitted urgently due to imminent date of service is not considered to be urgent. Urgent request should only be used when care is needed within **24-72 hours** or the member is at risk for serious harm should care be delayed. Inappropriate use of the "urgent" category will be monitored.

Retrospective/Post Service Process

Retrospective/post-service review is the process in which utilization review is used to determine medical necessity or coverage under the health plan benefit. This review is conducted after health care services or supplies have been provided to a member.

The Alliance does not require prior authorization (PA) for emergency or urgent services. To obtain a PA for non-emergency or non-urgent services, the Alliance offers access to submit requests through the Alliance UM Department, 24 hours a day, 7 days a week.

Alliance UM Department
Phone Number: **1.510.747.4540**
To submit a request via E-Fax line: **1.855.891.7174**

The Alliance maintains and publishes a list of services that require PA. The list is accessible at **www.alamedaalliance.org/providers/medical-management**.

Requests are reviewed based on Alliance policies and established practices for medical necessity. The Alliance does not accept non-emergency or non-urgent services that require PA after the date of service.

The following retrospective request exceptions will be considered:

- Post stabilization
- Provision of inpatient services where the facility is unable to confirm enrollment with the Alliance
- Requests due to member eligibility issues

Post-service requests submitted within **30 calendar days** of the date of service, and when a claim is not on file, will be reviewed by the Alliance UM Department. Turnaround times for review will follow state regulatory guidelines.

Please Note: Retrospective/post-service requests are not urgent and will not be processed as such. Post-service requests submitted after **30 calendar days** from the date of service should be submitted with your claim and will be processed via the Retro Claims Submission Review process. Requests for services that do not meet the criteria above are subject to denial as no authorization has been obtained.

TRACKING AND MONITORING OF SERVICES AUTHORIZED

The Alliance tracks and monitors services authorized to specialists, including open or unused approved authorizations. This process is in place to ensure that services authorized are utilized within the authorized time duration. A monitoring report will be reviewed to evaluate whether there are access constraints for certain providers and specialties, as well as identify any members who continuously not utilize approved authorizations for possible referral to case management to help coordinate their care.

DELEGATION OF UM TO MEDICAL GROUPS

Members may be assigned to a PCP that are not directly contracted with the Alliance who belongs to one of the following medical groups:

- Children First Medical Group (CFMG) - Medi-Cal only
- Community Health Center Network (CHCN) – Medi-Cal and Group Care
- Kaiser Foundation Health Plan (Kaiser) – Medi-Cal only

Our medical groups adhere to the same regulatory standards for UM as outlined above. With some exceptions, a provider serving an Alliance member as part of a medical group must verify authorization rules and obtain any required authorizations from the medical group. Providers can verify a member's group assignment by using one of the Alliance's eligibility verification methods.

DURABLE MEDICAL EQUIPMENT (DME)

The Alliance contracts with California Home Medical Equipment (CHME) for authorization management and servicing for the majority of DME services to all members in all medical groups, except Kaiser.

CHME manages the following service categories:

- Breast pumps
- Home respiratory equipment
- Hospital beds
- Incontinence supplies
- Nutritional supplements and feeding supplies
- Wheelchairs, walkers, and canes
- Other home medical supply needs

PA requests for DME should be directed to CHME for processing.

A complete list of services managed by CHME is available online at **www.alamedaalliance.org**. For services excluded from CHME's management, the Alliance contracts with a select group of providers. Providers should submit a PA request directly to the Alliance UM Department for these excluded services for all members in all medical groups, except Kaiser. A list of services excluded from CHME and preferred alternate vendors is available at **www.alamedaalliance.org**.

DIVISION OF UM RESPONSIBILITY WITH ALLIANCE MEDICAL GROUPS AND VENDORS

This grid is meant to direct providers to submit prior authorizations to the correct entity.

Delegated Medical Group	Phone	Fax	Website
Children First Medical Group	**1.510.429.3489**	**1.510.450.5868**	**www.childrenfirstmedicalgroup.org**
Community Health Center Network	**1.510.297.0220**	**1.510.297.0222**	**chcnetwork.org**

For further details about the authorization review process for specific services, please visit **www.alamedaalliance.org/providers/medical-management**.

Provider-To-Provider Communication

In order to ensure coordinated care when referring members for specialty services, the following communication and documentation guidelines must be followed.

PCPs

Provide the specialist with the following information:

- Condition/reason for referral
- Document the referral in the member's medical record
- Member's name / Alliance ID number
- Member's preferred language
- PCP's name
- Provide the member with the referral information
- Refer to network providers only – check the most recent online provider directory for a complete listing of current Alliance specialists
- Relevant clinical information

SPECIALISTS

- Verify the member's eligibility at the time of service.
- Document the referral information in the member's medical record.

- Provide regular feedback to the PCP.
- Verify the referral from the member's PCP or obtain authorization from the Alliance for services requiring prior authorization (PA).

Mental Health Services

SPECIALTY MENTAL HEALTH SERVICES

Members are eligible to get specialty mental health services from Alameda County Behavioral Health Plan (ACCESS) program.

Providers must immediately refer Medi-Cal members who present any of the following conditions to the county:

- Psychotic Disorders
- Severe Bipolar Disorder
- Severe Major Depression
- Any mental disorder that causes an imminent risk to the member or community

Providers should also contact ACCESS for urgent conditions to receive a triaged consultation.

An "urgent condition" is defined as a situation experienced by a member that without timely intervention is certain to result in an immediate emergency psychiatric condition.

These referrals can be made 24 hours a day, 7 days a week by calling the ACCESS helpline for Medi-Cal members:

Phone Number: **1.510.346.1000**
Toll-Free: **1.800.491.9099**

If a member's mental disorder is outside the scope of the provider's practice or is not responsive to treatment, the provider may also refer the Medi-Cal member to specialty mental health care by calling ACCESS.

Medi-Cal members 18 to 64 years of age may directly access specialty mental health care by calling ACCESS. The County will provide consultations by phone to Alliance PCPs. Consultations are available Monday – Friday, 8 am – 5 pm, through the ACCESS helpline.

OUTPATIENT MENTAL HEALTH SERVICES

The Alliance provides outpatient mental health services through its mental health delegate, Beacon Health Options (Beacon). For Medi-Cal, these include mild to moderate mental health conditions. For Group Care, these include outpatient and specialty mental health services.

The following outpatient mental health services for the treatment of mild to moderate mental health conditions are provided:

- Psychiatric consultation and medication management
- Psychological testing, when clinically indicated to evaluate a mental health condition
- Psychotherapy, individual and group

BEHAVIORAL HEALTH TREATMENT (BHT)

The Alliance covers BHT for Autism Spectrum Disorder (ASD). This treatment includes Applied Behavior Analysis (ABA) and other evidence-based services.

BHT services must be:

- Administered in accordance with the beneficiary Plan-approved treatment plan
- Approved by Beacon on behalf of the Alliance
- Medically necessary
- Members may qualify for BHT services if they:
    - Have a diagnosis of ASD
    - Have behaviors that interfere with home or community life. Some examples include anger, violence, self-injury, running away, or difficulty with living skills, play and/or communication skills
    - Under 21 years of age
- Prescribed by a licensed doctor or a licensed psychologist

Members do not qualify for BHT services if they:

- Are not medically stable
- Have an intellectual disability (ICF/ID) and need procedures done in a hospital or an intermediate care facility
- Need 24-hour medical or nursing services

Members or their authorized representatives can call Beacon directly to be referred for services or if they have any questions at **1.855.856.0577**.

Minor Consent Services

Children 18 years of age or under may get certain confidential services without parent approval.

Minor consent services are services related to:

- Diagnosis and treatment of sexually transmitted diseases
- Drug or alcohol use services*
- Family planning services
- Medical care after a sexual assault

- Outpatient mental health care services*
- Pregnancy

*Children must be 12 years of age or older to receive drug and alcohol abuse services and outpatient mental health care services without parent approval.

Providers can call the Alliance Member Services Department to find out how to coordinate minor consent services. Members can also receive minor consent services from a non-Alliance provider that accepts Medi-Cal. PCPs do not have to authorize these services.

Vision Care Services

The Alliance contracts with March Vision Care to provide routine eye care services to Alliance Medi-Cal members and covers:

- Routine eye exam once every 24 months
- Eyeglasses (frames and lens) once every 24 months; contact lens when required for medical conditions such as aphakia, aniridia and keratonconus.

Prior authorization (PA) is not needed for appointments.

For questions or to request a provider directory, please contact:

March Vision Care
Toll-Free: **1.844.336.2724**
To request online: **www.marchvisioncare.com**

The March Vision Care provider will send a report to the patient's PCP after the visit which will include all diagnoses discovered during the vision exam. The vision provider will make a referral to the members PCP whenever a medical problem is detected.

Group Care members have access to vision care services through their specific plans. Members should contact their vision plan for more information.

Hospice Services

The Alliance will provide reimbursement for hospice care for members who are certified as terminally ill by a physician and who directly, or through their representative, voluntarily elect to receive such care in lieu of curative treatment related to the terminal condition.

A member who elects to receive hospice care must file an election statement with the hospice providing the care.
The election statement must include:

- Identification of the Hospice

- The member's or representative's acknowledgement that:
    - A member or representative may:
        - Execute a new election for any remaining entitled election period at any time after revocation;
        - Change the designation of a hospice provider once each election period; this is not a revocation of the hospice benefit.
- A member's voluntary election may be revoked or modified at any time. The member must file a signed statement with the hospice revoking the member's election for the remainder of the election period.
- The effective date of the election.
- The signature of the member or representative.
- They have full understanding that the hospice care given as it relates to the Member's terminal illness will be palliative rather than curative in nature.

Community-Based Adult Services (CBAS)

CBAS is an outpatient, facility-based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals and transportation to Alliance members. The Alliance authorizes CBAS services based on a referral from the member's PCP and an eligibility assessment completed by a CBAS service provider.

CBAS MEDICAL NECESSITY CRITERIA

Except for those residing in an Intermediate Care Facility, Developmentally Developed-Habilitative ICF/DD-H, members must meet all of the following medical necessity criteria to qualify for CBAS:

- A high potential exists for the deterioration of the member's medical, cognitive, or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization if CBAS services are not provided.
- The member has one (1) or more chronic or post-acute medical, cognitive or mental health condition(s) identified by the member's personal health care provider as requiring monitoring, treatment or intervention, without which the member's condition(s) will likely deteriorate and require Emergency Department (ED) visits, hospitalizations, or other institutionalization.
- The member's condition(s) require all core CBAS services performed on each day of attendance that are individualized and designed to maintain the ability of the member to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization.
- Core services include:
    - Meal service

  - Personal care services/social services
  - Professional nursing services (which includes observation, assessment, and monitoring of member's health status and medications; communication with member's healthcare providers regarding changes in health status; supervision of personal care services; and/or skilled nursing care and intervention)
  - Therapeutic activities
- The participant's network of non-CBAS center supports is insufficient to maintain the individual in the community, demonstrated by at least one (1) of the following:
  - The member has family or caregivers available, but those individuals require respite in order to continue providing sufficient and necessary care or supervision to the member.
  - The member lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision.
  - The member resides with one (1) or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the member.

Transgender Services

The Alliance covers medically necessary care for transgender members, consistent with the State Medi-Cal benefit APL 16-013, and following the World Professional Association of Transgender Health (WPATH) Standard of Care for Gender Dysphoria.

All services require prior authorization (PA).

Medically necessary covered services are those services "which are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness or injury" (Title 22 California code of Regulations *51303).

Gender dysphoria (defined by the Diagnostic and statistical Manual of Mental Disorders, 5th Edition: DSM-5) is treated with the following core services:

- Behavioral health services
- Hormone therapy
- Psychotherapy
- Surgical procedures that bring primary and secondary gender characteristics into conformity with the individual's identified gender

Examples of services may include:

- Gender Confirmation Surgery
- Hormone therapy or Pubertal Suppression for Children under age 18

- Treatment of Gender Dysphoria through Hormone Therapy for Adults over 18 years of age.

The following procedures are considered cosmetic when used to improve the gender specific appearance of an individual who has undergone or is planning to undergo sex reassignment surgery, including, but not limited to, the following:

- Abdominoplasty
- Blepharoplasty
- Breast augmentation
- Brow lifts
- Calf implants
- Face lift
- Facial bone reconstruction
- Facial implants
- Gluteal augmentation
- Hair removal (for example, electrolysis or laser) and hairplasty, when the criteria above have not been met
- Jaw reduction (jaw contouring)
- Lip reduction/enhancement
- Lipofilling/collagen injections
- Liposuction/body contouring
- Nose implants
- Pectoral implants
- Rhinoplasty
- Skin resurfacing
- Thyroid cartilage reduction (chondroplasty)
- Voice modification surgery
- Voice therapy

Second Opinions

PCPs, specialists, and members (if the practitioner refuses), have the right to request a second opinion from a qualified health professional, at no cost to the member, from the Alliance regarding proposed medical or surgical treatments from an appropriately qualified participating healthcare professional acting within their scope of practice who possesses a clinical background, including training and expertise, related to the particular illness, disease condition, or conditions associated with the request for a second opinion.

Second opinions from contracted providers do not require authorization and arranged through the member's assigned PCP.

The Alliance provides a second opinion from a qualified health care professional in the network, or arranges for the member to obtain one out of network, at no cost to the member.

A prior authorization (PA) from the Alliance is required to receive a second opinion from an out-of-network provider. The time frames for processing second opinions follow the standard authorization time frames.

The second opinion authorization or a denial shall be provided in an expeditious manner appropriate to the nature of the member's condition, and not to exceed **72 hours** after the Alliance's receipt of the request.

Coordination of Care

The Alliance provides comprehensive medical case management to all members. Comprehensive medical case management includes care coordination for medically necessary services provided to members within and outside of the Alliance's provider network based on the individual member's needs.

A. Primary Care Physician (PCP) Role

Continuity and Coordination of care is ensured through the PCP who is formally designated as having primary responsibility for coordinating the member's overall health care. The PCP has the responsibility and authority to direct and coordinate the member's services. These responsibilities include: 1) Act as the primary case manager for all assigned members, 2) Assess the acute, chronic and preventive needs of each member, and 3) Employ disease management protocols to manage member's chronic health conditions.

B. Delivery of Primary Care

Establishment of an ongoing relationship between the member and their chosen PCP is crucial to the member achieving an optimal health status. Members are encouraged to make an appointment with their PCP immediately upon selection of their PCP. Primary care services will be available according to the health plan's established access and availability standards.

C. Coordination of Services

The PCP has primary responsibility for evaluating the member's needs before recommending and arranging the services required by the member, and facilitating communication and information exchange among the different providers/ practitioners treating the member.

Members are included in the planning and implementation of their care, with special emphasis on those members with mental health or substance abuse problems, co-existing conditions and chronic illnesses or those members at the "end of life". Members who are unable to fully participate in their treatment decisions (i.e., minors, incapacitated adults) may be represented by parents, guardians, other family members or conservators, as appropriate, and in accordance with the member's wishes.

The Alliance offers care coordination for the following services:

- Alcohol and substance use disorder treatment services
- Behavior health care
- California Children's Services (CCS)
- Children with special health care needs
- Dental services
- Direct observed therapy (DOT) for treatment of tuberculosis (TB)
- Early intervention service with the Early Start Program
- Excluded services requiring member disenrollment
- Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) waiver program
- Local Education Agency services (LEA)
- School-linked Child Health and Disability Prevention Program (CHDP) Services
- Services for persons with developmental disabilities (Regional Center)
- Services with out-of-network provider
- Waiver Program
- Women, Infants, and Children (WIC) Supplemental Nutrition program

i. Alcohol and Substance Use Disorder Treatment Services

PCPs are responsible for identifying members with active or potential substance use problems. Once members are identified, PCPs are responsible for providing services for the substance use problem within their scope of practice (counseling and/or treatment) and for performing the appropriate medical work-up given the nature of the substance use problem. PCPs are also responsible, with the assistance of the Alliance, for referring members with substance use problems to an appropriate treatment practitioner or county department.

ii. Behavioral Health Care

The Alliance collaborates with its behavioral health specialists to identify opportunities to improve coordination of behavioral health care with general medical care that may include, but is not limited to collaboration between organization and behavioral health specialists.

iii. California Children's Services (CCS)

PCPs and specialists are responsible for early identification of members that may have eligible CCS conditions. Medically necessary health care services will be administered throughout the referral process with the Alliance, regardless of whether or not the child is accepted into the CCS program (e.g. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for Medi-Cal members). The Alliance will consult and coordinate CCS referral activities with the local CCS Program in accordance with the MOU.

iv. Children with Special Health Care Needs

The Alliance will assist with referrals/authorizations and care coordination to ensure that members receive the care appropriate for their medical, mental, or physical condition.

v. Dental Services

Dental services are not covered by Medi-Cal managed care. However, the Alliance will ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists.

vi. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)

DOT is offered by the local health departments (LHDs) and is not covered by Medi-Cal managed care. PCPs will assess the risk of noncompliance with drug therapy for each member who requires placement on anti-tuberculosis therapy.

vii. Early Intervention Service with the Early Start Program

PCPs are responsible for assessing children's developmental status during well child exams, or at other medical encounters as appropriate. Children from birth to 36 months identified at risk for, or suspected of having, a developmental disability or delay must be referred to the Regional Center of the East Bay (RCEB) for evaluation for the Early Start Program. The Alliance will collaborate with RCEB or local Early Start Program in determining the medically necessary diagnostic and preventive services and treatment plans for members participating in the Early Start program.

viii. Excluded Services Requiring Member Disenrollment

For services related to long-term care and major organ transplants, the Alliance will initiate the disenrollment process.

ix. Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver Program

Services provided under the HIV/AIDS Home and Community Based Services Waiver Program are not covered by Medi-Cal managed care. However, contracted PCPs and specialists (practitioners) have the responsibility to identify and refer Medi-Cal managed care members to a HIV/AIDS waiver program if they meet criteria.

x. Local Education Agency Services (LEA)

Services provided by Local Education Agencies (LEA) are not covered benefits under Medi-Cal managed care but are covered under Medi-Cal fee-for-service. On an as needed basis, the Alliance will work with the PCP to coordinate care for a member to ensure the provision of all medically necessary covered diagnostic, preventive and treatment services identified in the Individual Education Program (IEP) developed by the LEA, with the PCP's participation.

xi. School-Linked Child Health and Disability Prevention Program (CHDP) Services

All pediatric members will be assigned to a PCP who will be their "medical home." The Alliance will coordinate with school-linked CHDP Services in order to assure access for child and adolescent members to preventive and early intervention services.

xii. Services for Persons with Developmental Disabilities (Regional Center)

Contracted PCPs and specialists (practitioners) are responsible for the identification and referral of members with developmental disabilities/ behavioral health disorders outside their scope of practice. The Alliance implements and maintains systems to identify members with developmental disabilities that may meet requirements for participation in a Home and Community Based Services (HCBS) Waiver Program and ensures that these members are referred to the appropriate HCBS Waiver Program administered by the California Department of Developmental Services.

xiii. Services with Out-of-Network Providers

The Alliance has identified members who may need or who are receiving services from out of plan providers and/or programs in order ensure coordinated service delivery and efficient and effective joint case management.

xiv. Waiver Program

Members who may qualify for one of the Waiver Programs will be identified by their PCP, with the Alliance UM Department support, based on their diagnosis and need for a specific level of care Authorization of Services should be medically necessary and recommended by the PCP or the specialty care provider (SCP). Members have a right to request any covered services, whether or not the service has been recommended by the PCP/SCP. The services must be approved through a utilization management system (either the health plan or the delegated Medical Group/IPA) based on medically necessity.

xv. Women, Infants, and Children (WIC) Supplemental Nutrition Program

The Alliance PCP, Obstetrical (OB), and pediatric practitioners will inform members of the availability of WIC services and make appropriate referrals to the local WIC program for their assigned members who are potentially eligible for WIC services.

Coordination of Care – California Children's Services (CCS)

Primary Care Providers (PCPs) and specialists are responsible for:

- Early identification and referral of children with potentially eligible conditions to CCS.
- Notifying the Alliance Utilization Management (UM) Department of members referred to CCS.
- Administering medically necessary health care throughout the referral process, with the Alliance, regardless of whether or not the child is accepted into CCS. E.g. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for Medi-Cal members.

CCS is responsible for:

- Treatment for CCS eligible conditions.
- Reimbursement of CCS-paneled providers and CCS-approved hospitals.
- Covering EPSDT services related to the CCS condition for Medi-Cal members.

Transportation

The Alliance provides the following transportation benefits to Medi-Cal members for all medically necessary services covered by the Alliance:

- Courtesy Transportation
- Non-Emergency Medical Transportation (NEMT)
- Non-Medical Transportation (NMT)
- Emergency Medical Transportation

The Alliance provides the lowest cost modality of transportation that is adequate for the member's needs. The Alliance will only provide transportation services that were approved by the Alliance and its transportation vendor.

The following guidelines will be used when reviewing requests for transportation services:

1. **Courtesy Transportation** is provided to members for their first three (3) transportation requests in order to ensure timely access to care. When a member contacts the Alliance's transportation vendor requesting transportation, a packet with three (3) round-trip public transit vouchers is mailed to the member to allow immediate access to care. No prior authorization (PA) is required for NMT services. For non-emergency transportation services, the physician approval for the level of services is still required but will not delay the member's care needed.
2. **Non-Emergency Medical Transportation (NEMT)** is covered for all medically necessary Medi-Cal services covered by the Alliance. The Alliance shall provide medically appropriate NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically

necessary services. NEMT is provided for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. The Alliance shall ensure door-to-door assistance for all members receiving NEMT services. The Alliance shall ensure that the medical professional's decisions regarding NEMT are unhindered by fiscal and administrative management, in accordance with their contract with Department of Health Care Services (DHCS).

3. Requests for transportation services must be submitted and meet the following requirements:

    i) The Alliance's Physician Certification Statement (PCS) form signed by the treating physician or mid-level provider (MD, DO, PA, or NP) is required in order to determine the appropriate level of service. Providers must use the Alliance's Department of Health Care Services (DHCS) approved PCS form.

        (a) The PCS form collects data regarding the member's functional limitations, prescribed dates of service, and prescribed mode of transportation. The provider must also attest that medical necessity was used to determine the type of requested transportation. The provider must document the member's functional limitations justification on the PCS form to provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicle.

            (i). Based on medical necessity, a provider may prescribe NEMT for up to 12 months for members on dialysis, chemotherapy, or other infusions.

        (b) The completed PCS form must be submitted to the Alliance's transportation vendor for coordination of services. The PCS form must be completed before NEMT services can be prescribed and provided to the member. PCS form includes the certification statement (prescribing physician's statement certifying that medical necessity was used to determine the type of transportation being requested). The signed PCS form with the required fields will be considered completed.

        (c) Once the completed PCS form is received by the Alliance's transportation vendor, it may not be modified. The Alliance and its transportation vendor coordinate with the prescribing provider to ensure the PCS form submitted captures the lowest cost type of NEMT transportation (see modalities below) that is adequate for the member's medical needs.

(d) The Alliance captures data from the PCS form for reporting and submitting the data to the DHCS.

ii) NEMT is also provided for a parent or guardian when the member is a minor. The Alliance provides transportation for unaccompanied minors with written consent of a parent or guardian or when applicable state or federal law does not require parental consent for the minor's service.

iii) NEMT is provided in the following modalities and situations:

(a) NEMT ambulance services are provided for:

(i). Transfers between facilities for members who require continuous intravenous medication, medical monitoring or observation.

(ii). Transfers from an acute care facility to another acute care facility. Members transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility or an intermediate care facility licensed. These NEMT services do not require the PCS form.

(iii). Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).

(iv). Transport for members with chronic conditions who require oxygen when monitoring is required.

(b) Litter van services are provided when the member's medical and physical condition does not meet the need for NEMT ambulance services but meets both of the following:

(i). Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport.

(ii). Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.

(c) Advanced Life Support services are provided when the member requires a paramedic during transport.

(d) Critical Care Transportation/Specialty Care Transportation services are provided when the member's condition requires cardiac monitoring.

(e) Life Support (LS) services are provided when the member's condition requires oxygen that is not self-administered or regulated.

(f) Wheelchair van services are provided when the member's medical and physical condition does not meet the need for litter van services but meets any of the following:

(i). Renders the member incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport.

(ii). Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle and place of treatment because of a disabling physical or mental limitation.

(iii). Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.

(g) NEMT by air is provided only when transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order of a physician or mid-level provider.

iv) For Medi-Cal services not covered by the Alliance, including specialty mental health, substance use disorder, dental, and any other services delivered through the Medi-Cal fee-for-service (FFS) delivery system or California Children's Services (CCS), the Alliance will make its best effort to refer and coordinate NEMT for members whose condition necessitates one of the above forms of transportation.

4. **Non-Medical Transportation (NMT)** is covered for all round trip transportation to medically necessary services covered by Medi-Cal. NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances. Requests are submitted to and processed by the Alliance's transportation vendor. The Alliance shall provide NMT in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws. Requesting providers may submit a PCS form to the Alliance's transportation vendor to request NMT services on behalf of members. Members may also call the Alliance or its transportation vendor directly to request for NMT services.

i) Based on medical necessity, a provider or member may request NMT for up to 12 months. Members on dialysis, chemotherapy, or other infusions will be automatically approved for NMT services for the 12 month duration. After the 12 month period, the Alliance will confirm if the level of NMT is still appropriate for the member's medical condition with their provider to continue services.

ii) NMT is also provided for a parent or guardian when the member is a minor. The Alliance provides transportation for unaccompanied minors with written consent of a parent or guardian or when applicable state or federal law does not require parental consent for the minor's service.

iii) NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation. This must be requested at time of initial NMT request.

iv) NMT is provided using the lowest cost modality appropriate for the member's condition. NMT modalities include the following:

(a) Public transportation/mass transit

(b) East Bay Paratransit

(c) Taxicab/Curb-to-curb passenger vehicle

(d) Door-to-door passenger vehicle

(e) Any other form of private conveyance (private vehicle), including mileage reimbursement consistent with the IRS rate for medical purposes when conveyance in a private vehicle is arranged.

(i). Members seeking NMT must attest to the Alliance's transportation vendor in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member does not have a valid driver's license, no working vehicle available in the household, unable to travel or wait for medical or dental services alone, or has a physical, cognitive, mental, or development limitation.

(ii). In order to receive gas mileage reimbursement for use of a private vehicle, the following documentation must be submitted to the Alliance's transportation vendor to document compliance with all California driving requirements, including:

1. Valid driver's license,

2. Valid vehicle registration, and
3. Valid vehicle insurance.

v) NMT services for Medi-Cal carved out services will be provided upon member or provider request to the Alliance. NMT can still continue to be provided through Medi-Cal Fee for Service agencies, such as CCS, if requested directly to the agency.

5. **Emergency Medical Transportation** is provided when a member's medical condition is acute and severe, necessitating immediate medical diagnosis to prevent death or disability. Requests do not require prior authorization (PA). The following guidelines apply to Emergency Medical Transportation:

   i) Emergency Medical Transportation by air is covered only when medically necessary and when other forms of transportation are not practical or feasible for the patient's condition.

   ii) Ground Emergency Medical Transportation is covered when ordinary public or private medical transportation is medically contraindicated and transportation is needed to obtain care.

   iii) Emergency transportation must be to the nearest hospital capable of meeting the medical needs of the patient.

   iv) Medical transportation which represents a continuation of an original emergency transportation event does not require prior authorization (PA).

Section 7: Claims

Claims Overview

CLAIM REQUIREMENTS

The Alliance has established requirements for filing a claim for payment consideration. These requirements include that the claim is valid and complete, furnished within a prescribed time, and delivered to the correct business address. Failure to comply with these requirements may jeopardize the claim for reimbursement.

To be accepted as a valid claim, the submission must meet the following criteria:

- Must be submitted on a standard current version of a CMS 1500, CMS-1450 (UB04), or the ANSI X12-837-5010 (current version electronic format).
- Must contain appropriate information in all required fields.
- Must be a claim for an Alliance member eligible at the time of service. (Always verify eligibility via the Alliance web portal or calling by Member Services).
- Must be an original bill.
- Must contain correct national standard coding, including but not limited to CPT, HCPCS, NDCs Revenue, and ICD-10 codes.
- Must not be altered by handwritten additions to procedure codes and/or charges.
- Must be signed by the rendering provider, if paper.
- Must be printed with dark ink that is heavy enough to be electronically imaged, if submitted as a paper claim.
- Must be received within **180 days** from the service date.
- Must submit attachments on an 8 ½ x 11 sheet of paper and be legible.

Submitting a Claim

HEALTH INSURANCE CLAIM FORM (CMS 1500) – PROFESSIONAL CLAIMS

The Centers for Medicaid and Medicare Services (CMS) form 1500 must be used to bill the Alliance for medical services. This form is used by physicians and allied health professionals to submit claims for medical services.

HEALTH INSURANCE CLAIM FORM (CMS 1450) – FACILITY CLAIMS

A CMS 1450 (UB-04) is the only acceptable claim form for submitting inpatient or outpatient hospital (technical services only) charges for reimbursement by the Alliance. In addition, a CMS 1450 is required when billing for nursing home services, swing bed services with revenue and occurrence codes, inpatient hospice services, Ambulatory Surgery Centers (ASC) and dialysis services. Incomplete or inaccurate information will result in the claim/encounter being rejected or denied for corrections.

PAPER CLAIMS SUBMISSION

Paper claims for Alliance members should be submitted for payment as follows:

Professional Medical Service Claims	If the member/patient is assigned to an Alliance **PCP:** Alameda Alliance for Health P.O. Box 2460 Alameda, CA 94501-0460 If the member/patient is assigned to a **CHCN PCP:** Community Health Center Network 101 Callan Ave., 3rd Floor San Leandro, CA 94577 If the member/patient is assigned to a **CFMG PCP:** Children's First Medical Group P.O. Box 99680 Emeryville, CA 94662-9680
Institutional (Hospital, SNF, etc.) Services Claims	Hospital/Facility Claims for all Alliance members Alameda Alliance for Health P.O. Box 2460 Alameda, CA 94501-0460
Behavioral Health Claims	Beacon Health Options P.O. Box 1862 Hicksville, NY 11802-1862 **www.beaconhealthoptions.com**
Vision Claims	MARCH Vision Care (Medi-Cal only) Attn: Claims Department 6701 Center Drive West, Suite 790 Los Angeles, CA 90045 **www.marchvisioncare.com**
Dental Claims	Denti-Cal (Medi-Cal only) P.O. Box 15610 Sacramento, CA 95852-0610

ELECTRONIC CLAIMS SUBMISSION

The Alliance offers providers the speed, convenience, and lower administrative costs of electronic claims filing, also known as Electronic Data Interchange (EDI). Providers interested in submitting claims electronically should call the Alliance Provider Services Department at **1.510.747.4510**.

Claims that require attachments may not be sent electronically. They must be submitted using the appropriate paper claim forms with the attachments.

TIMEFRAME FOR CLAIM SUBMISSION

All claims must be submitted timely for consideration of payment. Claims submitted after the appropriate filing deadline will be denied, unless documentation substantiating the delay in billing is provided. Claims submitted prior to the actual date of service (or date of delivery for supplies and DME) will also be denied.

Timely filing rules are as follows:

- When the Alliance is the primary payer on the claim:
- Participating (contracted) providers must submit claims post-service within the timely filing timeframe identified in your agreement with the Alliance. Post-service is defined as after the date of service for professional or outpatient institutional providers, or after the date of discharge for inpatient institutional providers.
- Unless otherwise indicated in your agreement, contracted providers must submit claims within **180 calendar days** post-service.
- When the Alliance is not the primary payer under Coordination of Benefits (COB):
- Providers must submit a claim to the Alliance within **180 days** from the date of payment or date of denial notice from the primary payer.
- Providers must also submit a copy of the Remittance Advice (RA)/Explanation of Benefits (EOB) from the primary payer which indicates the date of resolution by the primary payer, whether paid, contested, or denied.
- When an Alliance member does not present accurate insurance information, and another payer or the member is billed for the service:
- The provider must submit a claim to the Alliance within **60 days** of receiving the correct insurance information from the member or incorrect payer
- Provider must also submit proof that the member or another payer had been billed
- Claims or any portion thereof previously denied by the Alliance as an incomplete claim due to missing or invalid information:
- A corrected claim must be submitted for reconsideration of payment within **180 days** from the date of the original denial by the Alliance. A corrected claim may be mistaken as a duplicate claim submission unless it is clearly identified as such.

CLAIMS STATUS AND INQUIRY

Claim status can be verified for our contracted providers using our Online Provider Portal. Contact the Alliance Provider Services Department at **1.510.747.4510** for information regarding use and how to obtain a Provider Portal account if you do not already have one.

Providers should call the Alliance Provider Services Department at **1.510.747.4510** for more complex claim status questions or submission requirements. Alliance Provider Services Representatives can assist with resolution of complex claims issues and arrange for the adjustment of claims, if necessary.

PROOF OF TIMELY FILING

If a claim has been denied for timely filling, the following are acceptable forms of documentation for payment reconsideration:

- RA/EOB from the primary carrier
- Copy of enrollment card presented at time of service

MISDIRECTED CLAIMS

When a claim is incorrectly sent to the Alliance that should have been sent to one of its delegated partners (e.g., CHCN, CFMG, etc.), the Alliance will forward the claim to the appropriate delegated partner within **10 working days** of receipt of the claim. The provider will also receive a notice of denial with instructions to bill the delegated partner.

Claims Receipt and Determinations

ACKNOWLEDGEMENT OF CLAIM RECEIPT

The Alliance will acknowledge the receipt of an electronic claim within **2 working days** from receipt of the claim or within **15 working days** of receipt of the claim if it was submitted on paper.

CLEAN CLAIM

A clean claim is defined as a claim which, when it is originally submitted, contains all necessary information, attachments, and supplemental information or documentation needed to determine payer liability and make timely payment.

CLEAN CLAIM PROCESSING TIME

The Alliance will adhere to the following claims processing guidelines:

- 90% of clean claims within **30 calendar days** from receipt
- 95% of clean claims within **45 working days** from receipt
- 99% of clean claims within **90 calendar days** from receipt

INTEREST ON CLAIMS

The Alliance will calculate and automatically pay interest, in accordance with Assembly Bill (AB) 1455 requirements, to all providers of service who have not been reimbursed for payment, within **45 working days** after the receipt of a clean claim.

BILLING MEMBERS

Providers are prohibited from billing Alliance members for covered services. Under the Knox-Keene Act, Health and Safety Code 1379 of the State of California, it is illegal to bill a member who is enrolled in a state program for which services were provided. Alliance members are never responsible to pay participating providers any amount for covered medical services, other than approved co-insurance, deductibles or co-payment amounts as a part of the member's benefit package.

Providers may not seek reimbursement from the member for a balance due. Providers may not bill Alliance members for covered services, open bills, or balances in any circumstance, including when the Alliance has denied payment. In some cases, providers may bill members for co-payments, non-benefits and for non-covered services.

OVERPAYMENTS AND RECOUPMENTS

Overpayments can happen for many reasons, including, but not limited to:

- Alliance claim processing error
- Another party paid for covered services (i.e. coordination of benefits)
- Duplicate payment made by the Alliance when covered services are payable, in part or full, to another provider
- Retroactive change to eligibility

A written overpayment request will be sent to the provider within **365 days** of the date the original claim was paid. The provider must either contest or refund the requested monies within **30 working days** from receipt of the notification of overpayment. If the provider does not contest or refund the requested monies within **30 working days**, the Alliance may offset the requested amount against future claim payments, as documented in the contractual agreement.

COORDINATION OF BENEFITS (COB) is used to determine the order of payment responsibility when an Alliance member is covered by more than one health plan or insurer. The Alliance is always the payer of last resort for Medi-Cal members and all other coverage is primary. State and federal laws require providers to bill other health insurers prior to billing the Alliance.

COORDINATING BENEFITS

All claims must be submitted to the Alliance within **180 days** from the date of payment on the primary payer's RA/EOB. A copy of the RA/EOB must accompany the claim. If the primary payer denies services asking for additional information, the information must be submitted to the primary payer and the claim finalized prior to submitting the claim to the Alliance. Since a copy of the primary payer's RA/EOB must be submitted along with the claim, these claims must be submitted on paper. Claims submitted electronically where the member has other coverage will be denied with instructions to re-submit as a paper claim with the RA/EOB attached.

When the Alliance is the primary payer, providers are reimbursed at their full contracted reimbursement rate. When the Alliance is the secondary payer under COB rules, the Alliance will generally pay the lesser of the following amounts for covered services:

- The actual charge made by the provider, less the amount paid by the other coverage.
- The amount the Alliance would have paid if the individual did not have other coverage.

If the primary insurance payment exceeds the fully allowed contracted rate, neither the Alliance nor its member is financially responsible for any additional amount.

THIRD PARTY LIABILITY

Providers may often learn of a possible Third Party Liability (TPL) case before the Alliance. Therefore, providers must assist with recovery by promptly notifying the Alliance when a TPL case is discovered.

Notification and TPL information may be either mailed or faxed to:

Alameda Alliance for Health
Claims Department
P.O. Box 2460
Alameda, CA 94502-0460
Fax: **1.877.747.4506**

Providers must promptly notify the Alliance Claims Department of a TPL case when:

- The patient has filed or intends to file a claim or lawsuit against a third party for injuries;
- A third party that caused or allegedly caused the patient's injury has insurance that will cover the expenses.

Below are some situations where a possible TPL case may exist:

- Member involved in auto accident
- Member injured on premises owned by another (e.g., slip-and-fall)
- Member injured on the job (worker's compensation)
- Member injured by another's negligence

TPL SUBMISSION REQUIREMENTS

When a TPL case is identified, provider's staff should obtain the following information from the Member and forward it with the TPL Notification Form to the Alliance:

- Patient name, Social Security Number, address, and telephone
- Date of injury
- Attorney's name, address, and telephone number (if any)
- Third party's insurance carrier or attorney's name, address and telephone number (if known)

Providers should complete the TPL Notification Form found in Attachments & Forms.

Service Specific Information

AMBULANCE, EMERGENCY, URGENTLY NEEDED, AND POST-STABILIZATION CARE SERVICES

The Alliance is responsible for ambulance, emergency, urgent, and post-stabilization care services, whether services are obtained in or out of network.

The Alliance will make prompt determination and reasonable payment to, or on behalf of, the members for these services when the financial responsibility is that of the Alliance.

FAMILY PLANNING SERVICES AND SENSITIVE SERVICES

Family planning and sensitive services may be billed fee-for-service. All PCPs or OB-GYNs rendering family planning and sensitive services must be documented on the claim form. For Medi-Cal members, family planning and sensitive services may be obtained in or out of network without any prior authorization (PA) requirements. For Group Care members, family planning and sensitive services obtained in network do not require PA but services obtained out of network will require a PA.

STERILIZATION SERVICES (MEDI-CAL ONLY)

Written informed consent must be obtained from all members seeking sterilization services. This applies to tubal sterilization, vasectomy, and hysterectomy. For Medi-Cal members only, regulations require that a copy of the signed PM 330 consent form be submitted to payers before payment can be released. Consequently, the Alliance will not reimburse professional or facility fees associated with tubal sterilizations, vasectomies, or hysterectomies, unless an appropriately completed PM330 consent form is submitted by the primary surgeon.

HIV TESTING AND COUNSELING

PCPs rendering HIV counseling and testing to assigned members may bill fee-for-service for those procedures.

Providers, other than the assigned PCP, who render HIV counseling and testing services, may bill the Alliance fee-for-service.

MINOR CONSENT SERVICES (MEDI-CAL ONLY)

Minor Consent Services, described below, may be billed fee-for-service when rendered by a PCP to their assigned Medi-Cal members. Minor Consent Services include:

- Sexual assault
- Confirmation or rule out pregnancy
- Family planning
- Abortions
- Sexually transmitted diseases
- HIV testing

VACCINES

Providers must document administration of pediatric immunizations on the PM-160 form for Medi-Cal members. Administration of routine pediatric immunizations is a paid fee-for-service to the PCP. The appropriate administration codes must be submitted on the CMS 1500 and PM-160 (Medi-Cal only) forms.

Providers billing for services rendered to CHDP eligible children and youth must use national CPT-4 or HCPCS codes on an appropriate HIPAA-compliant national claim form and follow Medi-Cal billing practices; the PM 160 form is no longer required. For Medi-Cal members, PCPs have access to free vaccines through the Vaccines for Children (VFC) Program. To enroll, call the VFC Program directly. Community and County clinics should call **1.510.267.3230**. Private Providers should call **1.510.704.3750**. Vaccines not covered by the VFC Program should be billed directly to the Alliance for reimbursement.

LABORATORY: CLINICAL, CYTOPATHOLOGY, AND PATHOLOGY

Quest Diagnostics is the Alliance's contracted partner for most outpatient clinical laboratory services. With the exception of emergency, urgent, PCP covered labs, sensitive services, or labs specifically identified as reimbursed fee-for-service, laboratory services are carved out to the Alliance's capitated laboratory provider, Quest Diagnostics. Pathology services, identified as CPT-4 procedure code range 88300- 88399, are payable by the Alliance only when performed in conjunction with emergency or urgent care services, or surgical services performed in an inpatient hospital, out-patient hospital, or free- standing surgical facility setting.

OFFICE-BASED INJECTABLES

Except for injectables administered in an inpatient setting, claims for injectables administered in the office must include the National Drug Code (NDC) for each drug. Claims that do not include NDCs will be denied.

Code Sets

BILLING CODES

It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete or invalid codes will result in a potential denial of the claim and a subsequent delay in payment.

All providers need to bill with approved Medi-Cal codes. Using non-approved Medi-Cal codes will result in a denial of services.

If you use unlisted or miscellaneous approved Medi-Cal CPT-4 or HCPCS codes, notes and/or a description of services rendered must accompany the claim. Use of unlisted or miscellaneous codes will delay claims payment and should be avoided whenever possible. Claims received with unlisted or miscellaneous codes that have no supporting documentation may result in claim denial, and the member may not be held liable for payment.

Providers will also improve the efficiency of their reimbursement through proper coding and reporting of a member's diagnosis. We require the use and reporting on a claim of valid ICD-10 diagnosis codes, to the appropriate specificity, for all claims. This means that ICD-10 codes must be carried out to the fifth, sixth, or seventh-digit when indicated by the coding requirements in the ICD-10 manual. Failure to code diagnoses to the appropriate level of specificity will result in denial of the claim and a consequent delay in payment.

CODE AUDITING AND EDITING

The Alliance utilizes code-auditing software for automated claims coding verification, and to ensure that the Alliance is processing claims in compliance with general industry and Medi-Cal standards.

The code-auditing software takes into consideration the conventions set forth in the healthcare insurance industry, such as regulatory state and federal standards, the National Correct Coding Initiative (NCCI) and Medi-Cal guidelines.

Using a comprehensive set of rules, the code auditing software:

- Accurately applies coding criteria for the clinical areas of medicine, surgery, laboratory, pathology, radiology, and anesthesiology, as outlined by the American Medical Association's (AMA) CPT-4 manual.
- Evaluates the CPT-4 and HCPCS codes submitted by detecting, correcting, and documenting coding inaccuracies, including, but not limited to, unbundling, up-coding, fragmentation, duplicate coding, invalid codes or modifiers, and mutually exclusive procedures.
- Incorporates historical claims auditing functionality that links multiple claims found in a member's claims history to current claims to ensure consistent review across all dates of service.
- The Alliance reviews providers' claims billing patterns and requests medical records for review when needed. Providers are responsible to submit the requested medical records to the Alliance. Failure to comply with the request may lead to corrective action plans or possible hold on payments.

Section 8: Provider Dispute Resolutions (PDR)

The Alliance offers a fair, fast, and cost-effective dispute resolution mechanism to process and resolve provider disputes. A PDR request may be submitted in writing using the PDR Request Form. Dispute requests must be submitted within **365 calendar days** of the Alliance's most recent action on the disputed claim.

A contracted or non-contracted provider dispute is a provider's written notice challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted, or contested or seeking resolution of a billing determination or other contract dispute or disputing a request for reimbursement of an overpayment of a claim.

Each contracted provider dispute must contain, at a minimum, the following information: the provider's name; the provider's identification number; contact information; and:

- If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item, the date of service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect;
- If the dispute is not about a claim, a clear explanation of the issue and the provider's position thereon; and
- If the dispute involves an enrollee or group of enrollees: the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the date of service and the provider's position thereon.

All provider disputes must be sent to the following address:

Alameda Alliance for Health
P.O. Box 2460
Alameda, CA 94501-0460
Attn: Provider Dispute Resolution (PDR) Unit

Provider disputes that do not include all required information may be returned to the submitter for completion. An amended dispute which includes the missing information may be submitted within **30 working days** of your receipt of a returned provider dispute.

The PDR will be acknowledged within **15 working days** of the receipt date, and resolved within **45 working days** of the receipt date of the dispute.

If the Alliance never received a prior authorization request for services that have now been rendered, please submit a retrospective authorization request to the Alliance UM Department.

The Alliance allows providers to appeal decisions that resulted in the denial of authorization for clinical services. A provider can file a PDR to request reconsideration of a UM denial for clinical services that have already been rendered and after a claim has been denied for no authorization. Please follow instructions on the form when submitting a PDR.

The Alliance's determination is the final decision and will not be reconsidered if resubmitted.

For further instructions on how to submit a PDR Request, please call the Alliance Provider Services Department Monday – Friday, 8 am – 5 pm at **1.510.747.4510**.

Section 9: Service & Referrals for Adults – Adult Clinical Preventive Services

This section details the services for adults receiving benefits as required by state and federal regulations. The Alliance requires PCPs to follow uniform guidelines for adult periodic health examinations in accordance with the US Preventive Services Task Force's "A" and "B" recommendations in the *Guide to Clinical Preventive Services*.

The preventive guidelines can be found at **www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations**. PCPs are required to provide preventive health services to their assigned members.

In addition, all Alliance members over the age of 21 are required to receive an Initial Health Assessment (IHA) from their PCP, including a complete physical examination and history (see **www.alamedaalliance.org/providers/initial-health-assessment**). At that time, they should also complete a Staying Healthy Assessment (SHA).

For assistance in obtaining a copy of the Guide, providers may contact the Alliance Provider Services Department at **1.510.747.4510**.

OB/GYN SERVICE

Alliance members have open access to services provided by in-network OB/GYNs and qualified Family Practice Physicians. Gynecological services provided to a member in the provider's office do not require prior authorization (PA).

CANCER SCREENING

All generally medically accepted cancer screening tests are covered by the Alliance.

Screening and diagnosis of breast cancer is a covered benefit. Mammograms do not require prior authorization (PA). Treatment for breast cancer includes prosthetic devices or reconstructive surgery for a patient incident to mastectomy.

DOCUMENTATION

Documentation of all clinical preventive service encounters must be included in the member's medical record. The medical record will be reviewed for completeness during site reviews conducted by the Alliance.

Providers should report all adult preventive health encounters, whether capitated or fee-for-service, to the Alliance using the CMS 1500.

For more information on adult preventive health services, providers can access: **www.ahcpr.gov/clinic/uspstfix.htm**.

Immunizations

Vaccinations provided to Alliance members over age 18 do not require prior authorization (PA). Providers may bill the Alliance for administering the vaccine and submitting a CMS 1500 claim form.

Family Planning Services

Medi-Cal members are entitled to timely, convenient, and confidential access to the full range of family planning services. In accordance with federal regulations, Medi-Cal members are allowed freedom of choice in selecting a family planning provider. Therefore, Medi-Cal members may receive such services from a PCP, non-PCP, or an out-of-plan provider, without prior authorization (PA). Members enrolled in other Alliance product lines may see Alliance contracted providers for family planning services.

SCOPE OF SERVICES

The following family planning services (Medi-Cal members only) are covered for both in-network and out-of-plan providers:

- Abortions
- Diagnosis and treatment of STDs if medically indicated
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider, if provided in an ambulatory setting
- Health education and counseling necessary to make informed choices and understand contraceptive methods
- Laboratory tests if medically indicated as part of decision making process for choice of contraceptive methods
- Limited history and physical examination
- Pregnancy testing and counseling
- Provision of contraceptive pills/devices/supplies
- Screening, testing and counseling of members at risk for HIV; referral for treatment
- Tubal ligation
- Vasectomies

TYPES OF PROVIDERS WHO MAY RENDER FAMILY PLANNING SERVICES

The following types of contracted providers may provide family planning services, as listed previously, within their scope of practice to Alliance members:

- Assigned PCPs
- Family and general practitioners
- Pediatricians
- County and community clinics
- Obstetricians/Gynecologists and Certified Nurse Midwives
- Family planning clinics
- STD clinics

Nurse practitioners and physician assistants may provide family planning services through a contracted physician.

REFERRALS

If the member's family planning needs exceed the provider's scope of practice, the member should be referred to an appropriate family planning provider. This referral does not require prior authorization (PA) and can be made to a provider within or outside the Alliance provider network (Medi-Cal only).

Providers should assist members in identifying family planning providers. Refer to the Provider Directory, or encourage the member to call the Alliance Member Services Department at **1.510.747.4567**. The Alliance Member Services Department can provide referrals for family planning services.

INFORMED CONSENT

Providers must obtain signed informed consent for any invasive procedure done during a family planning visit, such as, insertion of Norplant or of an IUD and for sterilization. Although signed consent is not required for all family planning methods, providers must document that members have been informed of the full range of contraceptive choices.

OUT-OF-PLAN FAMILY PLANNING SERVICES FOR MEDI-CAL

Covered Out-of-Plan:

Medi-Cal members may access family planning services out-of-plan, but are encouraged to choose a plan provider in order to promote continuity of care. Out-of-plan family planning providers must be qualified to provide family planning services based on their licensed scope of practice. Medi-Cal members seeking care from an out-of-plan provider should be advised that services are limited to those listed under Scope of Services in this section.

Excluded Out-Of-Plan:

Out-of-plan providers will NOT be reimbursed for the following family planning services:

- Routine infertility studies or procedures
- Reversal of voluntary sterilization
- Hysterectomy
- Transportation, parking, and child care

Confidential Human Immunodeficiency Virus (HIV) Testing

The Alliance's policy is to ensure members receive information regarding access to confidential HIV counseling and testing. Alliance Medi-Cal members have the right to confidential HIV counseling and testing within and outside of the Alliance's provider network. Members enrolled in other Alliance product lines may see any Alliance contracted provider for HIV services.

IDENTIFICATION

The following procedures should be followed for identification of patients who may need confidential HIV counseling and testing:

- Perform a thorough history and physical exam, including taking a sexual history.
- Inquire about illicit drug use to identify members who may need HIV counseling and testing
- Refer members for HIV counseling and testing under the following conditions:
- Behavior / History Indications
- Child of an HIV infected woman
- Men who have had sex with men
- Persons who have had anal intercourse
- Received blood/blood transfusion before 1985 or in a country where blood was not tested for HIV
- Received drugs for sex
- Received money for sex
- Sex with prostitute/sex partner
- Use of intravenous drugs or other substances
- Behavior resulting in other blood to blood contact, Sadomasochism (S&M), tattooing, piercing, etc.
- Medical Indications
- All hemophiliacs
- Cervical cancer
- Hepatitis B or C
- Any other STD, i.e., Syphilis, Gonorrhea, Human papillomavirus, Chlamydia, Pelvic Inflammatory Disease
- Herpes zoster outbreak in a person under 50 years old
- Persistent, recurrent, or refractory vaginal candidiasis
- Tuberculosis, active disease in a U.S. native and TB patients unresponsive to treatment
- Unexplained, persistent weight loss, diarrhea or fever

All pregnant women should be offered and encouraged to have HIV counseling and testing whether or not they seem to be at-risk for HIV infection, in accordance with California law.

Call the County Office of Acquired Immune Deficiency Syndrome (AIDS) at **1.510.873.6500** for a complete list of test sites.

REFERRAL

Providers may refer a patient requesting confidential HIV testing to a confidential test site, family planning or sexually transmitted disease provider within the Alliance provider network for all product lines. Referrals to in-plan sites are encouraged; however, Medi-Cal members do have the option of seeking HIV testing through non-contracted providers.

Providers should advise any member who chooses to go to an out-of-plan confidential test site to sign a release of information form to allow his or her name to be submitted on the claim. If the claim is submitted without a name to determine eligibility for services, the Alliance will not reimburse the provider.

ALLIANCE-CONTRACTED TEST SITES

The following test sites are within the Alliance's network.

Test Site	Phone Number	Address
Alameda County Medical Center - Highland Hospital	**1.510.437.4800**	1411 E. 31st St. Oakland, CA 94602
Asian Health Services	**1.510.986.6800**	818 Webster St. Oakland, CA 94607
Axis Community Health Center	**1.925.462.1755**	5925 W. Las Positas Blvd. #100 Pleasanton, CA 94566
Berkeley Public Health Clinic	**1.510.981.5350**	830 University Ave. Berkeley, CA 94710
East Oakland Health Center	**1.510.430.9401**	7450 International Blvd. Oakland, CA 94621
Eastmont Wellness Center	**1.510.577.5668**	6955 Foothill Blvd. Oakland, CA 94605
La Clínica de la Raza - Clínica Alta Vista	**1.510.535.4000**	3451 E. 12th St. Oakland, CA 94601
Native American Health Center	**1.510.535.4460**	3124 International Blvd. Oakland, CA 94601
Planned Parenthood, Hayward	**1.510.733.1819**	1866 B St. Hayward, CA 94541
San Antonio Health Center	**1.510.238.5400**	1030 International Blvd. Oakland, CA 94606
Tri-City Health Center	**1.510.770.8133**	39500 Liberty St. Fremont, CA 94538
West Oakland Health Center	**1.510.835.9610**	700 Adeline St. Oakland, CA 94607

Please remember to report all AIDS cases to the County Communicable Disease Division at **1.510.267.3240**.

Abortion Services

The following guidelines apply to Alliance abortion services:

- In-network abortion services are available to all members without a referral or prior authorization (PA).
- Alliance Medi-Cal members have the right to abortion services within and outside of the Alliance provider network without a referral or PA.

- The Alliance will NOT reimburse for abortions provided by out-of-plan providers for Group Care members without PA.
- Every effort shall be made to assist the member seeking abortion services. This includes providing timely and appropriate counseling, education, information, and referral.
- Providers shall assist members in identifying abortion service providers. Providers should refer to the Provider Directory, or encourage the member to contact the Alliance Member Services Department.

Sterilization Services

Written informed consent must be obtained from all members seeking sterilization procedures in accordance with state law. This applies to all members regardless of the product line in which they are enrolled and includes services for tubal ligations, sterilization, vasectomies and hysterectomies.

A copy of the signed sterilization consent form must be maintained in the member's medical records. For Medi-Cal members, a copy of the consent must also be submitted to the Alliance in order to be reimbursed (see below). Consent submission to the Alliance only applies to Medi-Cal members. Providers do not need to submit a copy of the consent to the Alliance for members in other product lines.

Prior authorization (PA) is not required for tubal ligations or vasectomies. Prior authorization (PA) is required for hysterectomies.

REQUIREMENTS REGARDING CONSENT

The legal requirements listed below apply to the provision of sterilization services. Sterilization is covered only if all applicable requirements are met at the time the procedure is performed. If the Member obtains retroactive coverage, previously provided sterilization services for tubal ligations and vasectomies are not covered unless all applicable requirements and California State Law, including the timely signing of an approved sterilization consent form, have been met.

MEDI-CAL MANAGED CARE REQUIREMENTS

Alliance members enrolled in Medi-Cal Managed Care must meet the requirements of the law specific to Medi-Cal funded members. This means that a member cannot waive the **30 day** waiting period between date of written consent and the actual performance of the procedure unless an emergency situation is documented in accordance with Title 22 CCR 51305.1.

When submitting claims for Medi-Cal members, a copy of an appropriately completed PM 330 must be submitted with claim for vasectomies and tubal ligations. Failure to submit the PM 330 will result in denial of payment to all providers involved in the delivery of the service until a properly completed PM 330 is submitted. If the PM 330 has not been properly completed in accordance with Medi-Cal guidelines, payment may be denied.

Alcohol Misuse Screening and Counseling (AMSC)

Providers must at minimum conduct an annual screening of adult members 18 years of age and older for alcohol misuse and maintain documentation of alcohol misuse screening. The screening should be conducted with one of these tools:

1. The Alcohol Use Disorders Identification Test (AUDIT);
2. The abbreviated AUDIT-Consumption (AUDIT-C); or
3. A single questions screening, such as asking, "How many times in the past year have you had **four (4)** (for women and all adults older than 65 years) or **five (5)** (for men) or more drinks in a day?" These questions are included in the SHA.

BEHAVIORAL COUNSELING INTERVENTIONS

The Alliance will cover behavioral counseling interventions for members who screen positively for risky or hazardous alcohol use or potential alcohol use disorder. At risk members should be offered at least one, but up to a maximum of three behavioral counseling interventions per year.

REFERRALS FOR TREATMENT

Patients who, upon screening and evaluation, meet criteria for alcohol use disorder, or who have an uncertain diagnosis, must be referred for further evaluation and treatment to State-certified treatment services.

You can refer Alliance members who need treatment for alcohol and substance use disorder treatment services by calling the following contacts:

For Alliance Medi-Cal members:
Alameda County Behavioral Health, ACCESS
Toll-Free: **1.800.491.9099**

For Alliance Group Care members:
Beacon Health Strategies
Toll-Free: **1.855.856.0577**

Tobacco Cessation

Alliance providers are responsible for tobacco use tracking, counseling and referrals.

Providers should ask all patients about tobacco use at every visit and have a tobacco user identification system to track use. There are various ways to track:

- Record in the required Staying Healthy Assessment
- Record in your Electronic Health Record
- Use ICD-10 codes for nicotine dependence.
- Use CPT codes for tobacco cessation counseling

TOBACCO CESSATION COUNSELING

The Alliance covers the following types of tobacco cessation counseling and referrals:

- **Individual Counseling:** Providers can bill for tobacco cessation counseling.
- **Group Counseling:** Refer patients to Alliance Health Programs at **1.510.747.4577** for group classes.
- **Telephone Counseling:** Refer patients to the California Smoker's Helpline at **1.800.NO.BUTTS.** The Helpline also has special programs for pregnant smokers, teens and e-cigarette users.

For additional training and resources on tobacco cessation counseling go to **www.alamedaalliance.org/providers/provider-training**.

Section 10: Services & Referrals for Newborns, Children and Adolescents

This section describes health care services that children in the Alliance are entitled to receive. Like adults, children are entitled to some services outside of the scope of a provider's practice. In such cases, providers should make assessments and, as appropriate, referrals for the conditions covered in this section.

Newborn Services

ELIGIBILITY

Babies born to mothers who are Alliance members are covered by the Alliance during the "newborn period".

The newborn period is not the same for all lines of business, and is calculated as follows:

- Medi-Cal Newborns - covered for the calendar month of birth and the month after.
- If the mother does not apply for the baby to receive their own insurance benefits, the baby will not be eligible for services, including Alliance services, after the newborn period. When this occurs, providers will not receive reimbursement or capitation for the baby from the Alliance.
- The Alliance sends reminders regarding newborn eligibility to the mother and can assist by providing enrollment information. However, providers are encouraged to also remind the parent/guardian to obtain separate benefits for the newborn and to choose a health plan and a PCP for continuity of care.
- Group Care Newborns – covered from the date of birth through the first **30 days** of life only.
  Dependents are not eligible to enroll in the Alliance Group Care Program.

BILLING

Pediatric care will be paid on a fee-for-service basis for attending the delivery, routine newborn care, and sick newborn care during the newborn period. It is important to verify the mother's eligibility before providing service to the newborn.

PHENYLKETONURIA (PKU) TESTING & TREATMENT

Testing and treatment of PKU, including formulas and special food products, are a covered benefit based upon the following guidelines:

- Part of a diet prescribed by a licensed physician and managed by a health care professional in consultation with a physician who specializes in the treatment of metabolic disease and who participates in or is authorized by the Alliance; and

- Provided that the diet is deemed medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

Clinical Preventive Services for Children – Periodic Health Assessments

This section outlines the PCP's responsibilities for preventive care services for children.

Periodic health assessments must be provided by PCPs for all members ages 0 – 21, according to the periodicity schedule and content of the most current Bright Futures/American Academy of Pediatrics (AAP) recommendations for preventive pediatric health care.

If the provider sees a child for urgent care and that child is not yet assigned to a PCP, the provider will be reimbursed at the base Medi-Cal fee-for-service rate for care, including preventive care provided at that visit.

BLOOD LEAD SCREENING

The PCP must provide oral or written anticipatory guidance to a parent or guardian of the child that at minimum includes information on how children can be harmed by exposure to lead. This guidance must be performed at each periodic health assessment, starting at six (6) months of age and continuing until 72 months of age.

Blood lead screening is required for all children at 12 months and 24 months of age, when the provider becomes aware that a child between 12 and 72 months has no documented blood lead testing at either the 12 month or 24 month interval, the child becomes at increased risk, or the test is requested by the parent or guardian. The blood lead level test is not required if the parent or guardian refuses consent or the PCP determines it poses a risk to the child's health that is greater than the risk of lead poisoning. Any reason for not screening must be documented in the child's medical record. Blood lead screening encounters should be identified using the appropriate CPT codes.

PCPs must follow the Childhood Lead Poisoning Prevention Branch (CLPPB) guidance when interpreting blood lead level results and deciding on follow-up activities. CLPPB guidelines can be found at **www.cdph.ca.gov/Programs/ccdphp/deodc/clppb/pages/prov.aspx**.

WRITTEN RESULTS

For Medi-Cal members, PCPs must provide written results to the member (or member's parent or guardian, as appropriate) of the initial or periodic health assessments.

FOLLOW-UP ON MISSED OR CANCELED APPOINTMENTS

PCPs must follow-up on missed or cancelled appointments for preventive care. At least two attempts to contact the member should be made and documented in the medical record.

If the PCP is still unable to contact the member, the PCP should contact the Alliance Member Services Department, who will attempt to contact the member to assist in rescheduling the appointment.

DOCUMENTATION OF PREVENTIVE SERVICES

The DHCS Facility Site Review (FSR) requirements include outreach from the provider when members have missed appointments.

The process established onsite provides timely access to appointments for routine care, urgent care, prenatal care, pediatric periodic health assessments/immunizations, adult Initial Health Assessments (IHA), specialty care and appointments, and following up of missed or canceled appointments. Systems, practices and procedures used for making services readily available to patients will vary from site to site.

Missed and/or cancelled appointments, and contact attempts must be documented in the patient's medical record.

For all Alliance members, preventive services including visits and immunizations must be billed to the Alliance, using the CMS 1500 billing form.

Immunizations

STANDARDS

Immunization information is available from the Centers for Disease Control (CDC) at **www.cdc.gov/vaccines**.

PROMOTION

Pediatric immunizations must comply with the most recent standards of the "Pediatric Immunization Practices" (U.S. Public Health Service and AAP) and the "Recommended Childhood Immunization Schedule" (ACIP and AAP). These schedules are accessible via the Alliance website at **www.alamedaalliance.org**. Additional information is available on the web at **www.cdc.gov/vaccines/recs/schedules/default.htm**.

To increase immunization rates, all PCPs are encouraged to:

- Use each patient encounter as an opportunity to screen for needed immunizations. See the guides at the end of this section:
  - "How to Put Immunization Management into Infant and Toddler Medical Visits"
  - "The Guide to Contraindications to Basic Childhood Immunizations"
  - Inform the parent/guardian of the next scheduled immunization(s). Screen other children accompanying the member for immunization status. Members may access immunizations at county clinics or through the Public Health Department Immunization Programs. These providers are contracted with the Alliance and are reimbursed on a fee-for-service basis.

VACCINES FOR CHILDREN (VFC) PROGRAM (MEDI-CAL ONLY)

PCPs have access to free vaccines for Medi-Cal members 0 -18 years of age through the VFC Program. The administration fee for routine pediatric immunizations is paid on a fee-for-service basis for Alliance directly contracted providers. When the VFC Program does not provide the vaccine for the Medi-Cal program or other Alliance product lines, the PCP may bill the Alliance without prior authorization (PA) for the vaccine by submitting an invoice with the CMS 1500 claim form.

To contact the VFC Program:

- Community and County clinics should call **1.510.267.3230**
- Private Providers should call **1.510.704.3750**

IMMUNIZATION EDUCATION

Federal law requires that Vaccine Information Sheets be handed out (before each dose) whenever certain vaccinations are given. These sheets are produced by the CDC, which explains to vaccine recipients, their parents, or their legal representatives both the benefits and the risks of a vaccine.

All handouts can be downloaded from the Immunization Action Coalition website at: **www.immunize.org**.

VACCINE STORAGE

Providers must submit certification to the Child Health d Disability Prevention (CHDP) Program of their capacity to store vaccines for Medi-Cal members only. Providers are required to have a freezer and a refrigerator for vaccine storage.

DOCUMENTATION

Medical record documentation of member immunization status is required. Immunization status and immunizations given should also be documented.

REPORTING

Providers must report vaccine preventable diseases to the local health department, Division of Communicable Diseases Control and Prevention using the Confidential Morbidity Report Card.

Early Periodic Screening Diagnosis and Treatment (EPSDT) – Medi-Cal Only

EPSDT services are a benefit for Medi-Cal members under 21 years of age to help keep them healthy. Members must get the right health check-ups for their age and appropriate screenings to find health problems and treat illnesses early, such as a defect, physical or mental illness, or other condition. EPSDT services must be identified and referred in a timely manner.

METHODS OF SCREENING

- Well-child visits.
- Regular check-ups to look for any problems with the member's medical, dental, vision, hearing, mental health, and any substance use disorders. The Alliance covers screening services any time there is a need for them, even if it is not during a regular check-up.
- Preventive care can be shots. The PCP must make sure that all enrolled children get the needed shots at the time of any health care visit.

When a problem physical or mental health issue is found during a check-up or screening, there may be care that can fix or help the problem.

These services covered by the Alliance include:

- Behavioral Health Treatment for autism spectrum disorders and other developmental disabilities.
- Case management, targeted case management, and health education.
- Doctor, nurse practitioner, and hospital care.
- Home health services, which could be medical equipment, supplies, and appliances.
- Physical, speech/language, and occupational therapies.
- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to improve function or create a normal appearance.
- Shots.
- Treatment for vision and hearing, which could be eyeglasses and hearing aids.

OTHER EPSDT SERVICES

If the care is medically necessary and the Alliance is not responsible for paying for the care, then the PCP should refer the member to California Children's Services (CCS) get the right care they need.

These services include:

- Private duty nursing services.
- Treatment and rehabilitative services for mental health and substance use disorders.
- Treatment for dental issues, which could be orthodontics.

REFERRALS FOR EPSDT SERVICES

PCPs have a responsibility for identifying the need for EPSDT services (see EPSDT services definition in the Attachments at the end of this section) through routine primary care of Alliance member's 0-21 years of age.

Members/families must request EPSDT services through their PCP. An Alliance Authorization Request Form (AAR) must be submitted for EPSDT services. The Alliance will not pay for EPSDT services that have not received prior authorization (PA). If EPSDT services are rendered under emergency conditions, standard procedures for emergency care must be followed.

If an out-of-plan provider (such as a mental health specialist, school nurse, or family planning provider) who is providing services to an Alliance member determines that EPSDT services are needed, that provider must contact the Alliance Medical Services Department. The Alliance Medical Services Department will notify and consult with the member's PCP.

CASE MANAGEMENT & COORDINATION OF CARE

The PCP must maintain ongoing communication with the EPSDT services provider in order to ensure coordination of care. This communication shall be documented in the medical record. The PCP is still responsible for providing primary care services, diagnostic and treatment services, and appropriate referral for specialty care.

Women, Infants & Children (WIC)

The WIC Program provides supplemental food vouchers and nutritional counseling to pregnant and breastfeeding women, and to infants and children under the age of 5. Eligibility is based on income.

Alliance providers of pediatric care should ensure the appropriate and timely referral of infants and children to the WIC program. Alliance prenatal providers may refer pregnant women to WIC.

Early Intervention Services

The Early Start program is designed to provide comprehensive, coordinated and family-focused early intervention services to children from birth to age 3, which have, or are at risk for, developmental disabilities. Providers are responsible for the appropriate and timely referral of children from birth to age 3 to the Early Start program, and for participating in the coordination of care provided to children enrolled in Early Start.

IDENTIFICATION

PCPs are responsible, through the assessment and examination process, for identifying Alliance members with Early Start eligible conditions. Identification of the following conditions in a child 0 - 36 months of age requires a referral within **two (2) working days** to Early Start.

DEVELOPMENTAL DELAYS

A developmental delay may exist where there is a significant difference between the infant or toddler's current level of functioning and the expected level of development for his or her chronological age in one or more of the following developmental areas:

- Physical and motor including vision, hearing, and health status
- Communication
- Social or emotional
- Adaptive

REFERRALS

Providers should refer directly to the appropriate agency for the Early Start program as outlined below. Attempts should be made to obtain consent from the parents prior to making the referral. Providers must also release any requested information directly to the referral agency. Members may also self-refer into the Early Start program.

For developmental delays or disabilities or high risk infants, providers should refer to:

Regional Center of the East Bay
Phone Number: **1.510.383.1200**

Family Resource Network
Phone Number: **1.510.547.7322**

Help me Grow
Toll-Free: **1.888.510.1211**

CASE MANAGEMENT AND ON-GOING CARE

PCPs maintain responsibility for basic case management of a child enrolled in Early Start and for referrals for specialty care as indicated. PCPs should participate, as appropriate, in the development and monitoring of the Individual Family Service Plan managed by the referral agency. PCPs must also make medical reports available, as requested, to the early intervention team in order to support their completion of the Individual Family Service Plan within the mandated 45-day time limit after the referral is made.

Section 11: Perinatal Services

The Alliance defines perinatal services as care delivered to a pregnant woman to diagnose and manage the pregnancy and related conditions, the delivery, and the postpartum follow-up. The standards for the treatment of pregnant women in this section will help providers meet the goals we all share - healthy mothers and children.

The Alliance recognizes that the Medi-Cal enrollment process presents a challenge to providers in the provision of quality prenatal care. Many women enter the plan well into their pregnancies. Regardless of when a pregnant woman enters the plan, it is imperative that providers see pregnant women as soon as possible.

PRENATAL PROVIDER ROLE

Prenatal Providers should follow the same authorization protocols as PCPs.

The prenatal provider, during the course of the member's pregnancy, is considered the gatekeeper or manager of the member's care. As such, prenatal providers may refer members to specialty services, all such referrals and authorizations must be given prior to the provision of care. Retrospective authorization of services is not permitted.

Perinatal Services

PREGNANCY TESTING

Pregnancy testing is available to members through their PCP or from any Obstetrician/ Gynecologist (OB/GYN), or family planning provider. No prior authorization (PA) is needed. A Medi-Cal member may receive a pregnancy test within or outside of the Alliance network. Alliance members enrolled in Alliance programs other than Medi-Cal must receive pregnancy test services in-network.

PRENATAL CARE APPOINTMENTS

Entry into prenatal care does not require a referral or prior authorization (PA). Prenatal appointments should be scheduled within **one (1) week** of the member's request.

Members may go to any obstetric (OB) provider in the Alliance network, unless they are assigned to Kaiser or CHCN. Alliance members assigned to Kaiser must receive OB care from Kaiser Providers. CHCN members must receive OB care from a CHCN provider or a provider contracted with CHCN.

HIGH RISK PRENATAL CARE

If a member's medical history or current condition indicates she may have a high-risk pregnancy, the member may be referred to the following types of Alliance practitioners:

- Genetic counselors
- Tertiary ultra-sonographers

- Perinatologists and Obstetricians certified for high-risk care
- Pediatricians and Neonatologists for intensive newborn care and CHDP follow-up
- A Sweet Success affiliate for pregnancy and diabetes
- To find the above providers, please refer to the Alliance Provider Directory

DELIVERY

Members must deliver at an in-network hospital with which their prenatal provider is affiliated.

NOTIFICATION OF ADMISSION

The hospital is responsible for contacting the Alliance Medical Services department when the member is admitted for delivery within **one (1) working day** of the admission.

POSTPARTUM CARE

The routine postpartum visit should generally be provided **21-56 days** after delivery, although this interval may be modified if warranted by the needs of the patient. The postpartum review should include: interval history and physical examination, laboratory data as indicated, family planning counseling, and nutritional health education and psychosocial reassessments.

The Alliance reimburses fee-for-service for the postpartum visit using CPT Code 59430, as long as the date of service is on or between **21-56 days** from the date of birth.

NEWBORNS' & MOTHERS' HEALTH ACT

Notice during Prenatal Care

During the course of prenatal care, prenatal providers must give Alliance members written notice of their benefits coverage under the Newborns' and Mothers' Health Act of 1997 ("NMHA"). "A Healthy Pregnancy-the Alliance can Help!" has been developed and translated for this purpose and can be found in Section 10 Attachments of this manual.

Maternity Lengths of Stay

A health plan cannot require discharge from a maternity stay less than **48 hours** (vaginal delivery) or **96 hours** (cesarean section) unless certain criteria are met. The Alliance does not limit maternity lengths of stay. A decision to discharge must be made by the treating physician in consultation with the mother. The prenatal provider must then advise the mother that she may receive a post discharge follow-up visit within 48 hours of discharge.

PERINATAL ASSESSMENT

Many providers may be affiliated with the Comprehensive Perinatal Services Program (CPSP). The forms and protocols connected with this program satisfy Medi-Cal Managed Care requirements for perinatal assessment and intervention.

If a provider is not affiliated with CPSP, it is necessary to do comparable perinatal assessments. This assessment should be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit. Risks identified should be followed up on by appropriate interventions, which must be documented in the medical record. The assessment must also be kept in the medical record. The Alliance provides prenatal assessment forms in the Alliance threshold languages. The Alliance recommends all providers use the Alameda CPSP postpartum assessment.

Please see the referenced sections of this manual for details on how to refer to these programs or services:

- WIC
- CHDP
- Family Planning
- STD Screening & Treatment
- Genetic Screening & Counseling
- Dental Services
- Perinatal Health Education Classes and Handouts

PRENATAL CARE AND CONSULTATIONS BY PERINATOLOGIST

Perinatologists may provide three types of services to Alliance members:

- Consultations
- Routine OB care
- Perinatology OB care

The authorization and claims process that Perinatology practices must follow for each of these types of services is detailed below. Payment will be denied for any service that requires, but has not received, prior authorization (PA) from either the prenatal provider or the Alliance Medical Services department.

ROUTINE OB CARE (NOT PERINATOLOGY)

Routine OB care provided to Alliance members by a Perinatology practice, which is not Perinatology care, must be billed according to the standard OB billing procedures.

Routine OB care does not require an authorization number and will be paid at the applicable global rate.

ONGOING PERINATOLOGY CARE

If an Alliance member's total OB care must be managed by the perinatologist because of a high risk medical condition, the following procedures apply:

- The Perinatologist must submit an Alliance Authorization Request form to the Alliance in order to obtain authorization for that pregnancy to be billed fee-for-service by the perinatology practice. The medical condition necessitating perinatology management must be documented.

- The Alliance Medical Services department will issue an authorization number for all services related to that high-risk pregnancy.
- The CMS 1500 is submitted for all services rendered and payment is made on a fee-for-service basis. Each CMS 1500 must have the original authorization number issued for that pregnancy documented in Box #23.
- The Perinatologist is responsible for administration of the required Perinatal Assessments. Forms for this assessment have been developed and translated by the Alliance. They are available in Section 10 Attachments of this manual. Per Medi-Cal Managed Care direction, this assessment should be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit. Risks identified should be followed up on by appropriate interventions, which must be documented in the medical record. The assessment must also be kept in the medical record.

Reimbursement and Documentation of OB Services

- Use a HCFA 1500 (CMS 1500) form to bill for all prenatal, delivery and postpartum services.
- Submit claims within the following time frame:
- Initial prenatal visit - within **90 days** of the first prenatal visit.
- The balance of the prenatal care and the delivery - within **90 days** of the delivery postpartum office visit (must be provided between **21-56 days** after delivery date) - within **90 days** of the date of service.
- When submitting a claim for the initial prenatal visit:
- Use the attached list of ICD-10 codes to document a high risk pregnancy. The diagnosis code submitted on the initial prenatal visit claim will determine whether that visit is paid at the normal or at risk rate.
- When submitting a final claim for antepartum and/or delivery care, services will be paid according to the following:
    - Global payment when antepartum care and delivery services are provided.
    - Fee-for-service when antepartum care only is provided; determined by the total number of visits.
    - If only **two (2)** or **three (3)** antepartum visits are provided bill individually for each of these visits. If a total of **4**- **6**, or **seven (7)** or more visits are provided, bill the appropriate code for that number of visits (in addition to the initial visit).
    - Fee-for-service when delivery only.
- Post-partum office visit must be billed using CPT code 59430 and will only be reimbursed when the post-partum visit is between **21-56 days** after delivery.

SERVICES INCLUDED IN GLOBAL PAYMENTS FOR OB CARE

The following services are included in the risk-adjusted global OB payments:

- Prenatal visits
- Prenatal laboratory tests sent to Quest
- Hospital visits for delivery stays less than **72 hours**
- Health education, nutrition and psychosocial counseling provided by office staff, unless authorized by Alliance
- Hospital visits, except antepartum greater than **72 hours**
- Delivery

SERVICES NOT INCLUDED IN GLOBAL PAYMENTS FOR OB CARE

The following services are not included in the global OB payments and may be billed fee-for-service:

- Post-partum care (CPT Code 59430) only when provided **21-56 days** from delivery
- Pregnancy test (CPT Code 81025 only)
- Sonograms
- Immunizations
- Non-stress tests
- Abortions
- Tubal ligations
- Treatment of a sexually transmitted disease
- Family planning visit
- Lab tests included in the PCP capitation scope of service
- Amniocentesis
- Chorionic villus sample
- Prenatal genetic testing

Section 12: Out-of-Plan Services

Alliance Medi-Cal members are entitled to many services that are not provided through the Alliance. Providers must ensure that members have access to these out-of-plan services. The Alliance requires providers to assess each member for the various types of services included in this section and refer members appropriately.

California Children Services (CCS)

Alliance Medi-Cal members 0-21 years of age can receive care through California Children's Services (CCS) for specific eligible conditions as outlined in this section. CCS financial eligibility is automatic with Medi-Cal coverage. Providers treating a member with a CCS-eligible condition and/or an open CCS case should obtain authorization for services for that condition directly from CCS. The Alliance will also work directly with CCS to coordinate the payment of care; this involves referring eligible cases, obtaining authorization from CCS, and forwarding claims for payment if there is an open authorization. If the condition is not CCS-eligible or if CCS eligibility is uncertain, providers should follow the authorization procedures for the Medi-Cal Program members.

Please note that the provider must be an authorized (also known as paneled) CCS provider in order to provide care and receive compensation for treatment of a CCS patient for the eligible condition. To obtain more information about the paneling process and to submit an application, please visit **https://cmsprovider.cahwnet.gov/PANEL/index.jsp**.

CONDITIONS ELIGIBLE FOR CCS:

Please refer to the DHCS website for listing at **www.dhcs.ca.gov/services/ccs/Pages/default.aspx**.

ESTABLISHING A CCS CASE

Any provider, parent, social worker, or teacher may contact CCS to establish a case. Contacting CCS is not an authorization of service, but does establish the earliest date for which eligibility may apply and begins the process of opening the case. CCS referral, an Alliance authorization, or PCP referral must be in place for any services to be covered.

The Alliance will pay for all eligible medical and pharmacy services during the interim referral period and if CCS denies the case. PCPs that identify a condition which may require CCS services should complete an AAR for other services, such as, DME or inpatient and outpatient services. Submit the AAR to the Alliance. Completion of the form ensures that the provider will be paid by the Alliance if the condition is not medically eligible for CCS.

Indicate on the AAR that a referral to CCS is requested. The Alliance will refer any case to CCS whose diagnosis might meet CCS eligibility criteria. Members can begin care with the specialist immediately.

Providers do not have to wait for CCS to determine eligibility because the services have been authorized by the Alliance or the PCP and will be paid by the Alliance in the interim period.

DIRECT REFERRAL TO CCS

If providers wish to contact CCS directly, the following information is required:

- Patient name
- Date of birth
- Medi-Cal member identification number
- Name, address, and telephone number of the parent/legal guardian
- Address and telephone of child, if different
- Medical condition
- Referring provider's name and phone number
- Medical notes which must include plan of treatment

The information may be faxed or mailed to CCS. Identify the specialist for referral, if one has been selected. CCS will honor your request if the physician is CCS-paneled. Referrals should be made to specialists in the Alliance network who are also CCS paneled.

California Children Services (CCS)
1000 Broadway, Suite. 5000 Oakland, CA 94607 Phone Number: **1.510.208.5970** Fax: **1.510.267.3254**

Providers should also forward copies of medical reports that support the CCS-eligible condition or suspected condition. In addition to a history and physical, these might include laboratory test results, diagnostic imaging reports, and operative report or pathology findings.

COORDINATION OF CARE

PCPs are required to coordinate services with CCS specialty providers. If the member is eligible for CCS services, CCS will provide medical case management for the specific CCS condition. In all cases, PCPs must continue to provide primary case management to the member. Children with CCS eligible conditions should still see their PCP for routine care, urgent care of non-eligible conditions, and for preventive care, including immunizations.

CLAIMS

If the specialist has received CCS authorization for services, the specialty provider should submit claims for payment directly to the County CCS program. If CCS eligibility is pending or denied, specialty providers can send claims for care authorized by the Alliance or referred by an Alliance provider to the Alliance Claims Department. Upon CCS authorization, the Alliance will forward the claim to CCS.

Dental Screening – Medi-Cal

Dental screening is a component of a comprehensive health assessment for all members. PCPs should refer Medi-Cal members 0 – 20 years of age to fee-for-service Denti-Cal providers. Members may also self-refer to dental services.

IDENTIFICATION, DOCUMENTATION AND REFERRAL FOR CHILDREN

Dental screening for children is a required component of the CHDP exam. Mouth and teeth should be assessed and referrals made as follows:

- For children younger than three (3) years old, make a dental referral if any problems are suspected.
- For children 3 - 20 years old, ask the family/guardian if the child has seen a dentist in the past 12 months. A referral should be made if the child has not seen a dentist or a problem is identified.
- All dental assessments and referrals for children must be documented on the PM-160.
- Call CHDP at **1.510.208.5960** for a copy of the roster of dentists who accept Denti-Cal patients.

IDENTIFICATION, DOCUMENTATION AND REFERRAL FOR ADULTS

Medi-Cal does not pay for dental care for adults 21 years of age and older. PCPs should still assess whether adult patients have seen a dentist in the past 12 months. If not, adult patients should be encouraged to find a dentist who provides low-cost dental care. Call Denti-Cal at **1.800.322.6384**.

TOPICAL FLUORIDE VARNISH

Topical fluoride varnish is a benefit for Medi-Cal children younger than six (6) years of age, up to **three (3) times** in a 12-month period. In addition to dentists, physicians, nurses and medical personnel are permitted to apply fluoride varnish when the attending physician delegates the procedures and establishes protocol.

Tuberculosis (TB) Control Services

CLINICAL GUIDELINES

Providers should follow the guidelines of the American Thoracic Society in the provision of TB services. The Mantoux tuberculin test is the only screening test to be used.

Alliance providers must identify, refer, and coordinate services with the Alameda County Health Care Services Agency, Division of Communicable Disease Control and Prevention, or Directly Observed Therapy (DOT) or Directly Observed Preventive Therapy (DOPT) for tuberculosis. All suspected or confirmed TB cases should be reported to the TB Controller.

REPORTING

Per Title 17 of the California Code of Regulations, providers must promptly report all suspected or confirmed TB cases to the TB Controller within **one (1) day** of identification.

A completed Confidential Tuberculosis Report must be faxed to:

TB Controller
Division of Communicable Disease Control and Prevention
Phone Number: **1.510.577.7000**
Fax: **1.510.577.7024**

REFERRAL CRITERIA

Some TB patients may require more medical management than typically provided by a PCP.

Patients meeting any of the following criteria require a referral DOT or DOPT when there is suspected or diagnosed TB:

- History of previous TB treatment
- Patients on intermittent therapy
- Smear and culture positive **three (3) months** into therapy
- Patients whose treatment has failed, or who have relapsed after completing a prior regimen, or who demonstrate slow sputum conversion or clinical improvement
- Demonstrated drug resistance to either Isoniazid or Rifampin
- Adverse reaction to TB medications
- Immunocompromised, or at risk of being immunocompromised
- Too ill for self-management
- Children and adolescents
- Living in home with another case of DOT
- Homeless or shelter residents
- History of drug or alcohol abuse
- Poor or non-acceptance of TB diagnosis
- Individuals demonstrating non-compliance
- Major psychiatric, memory, or cognitive disorder
- Any patient the physician or nurse case manager deems at risk for non-compliance

Document the referral to DOT/DOPT in the member's medical record.

HOSPITAL DISCHARGE

Providers must notify the TB Control Unit at **1.510.208.5940** at least 24 hours prior to the anticipated hospital discharge of a member who is a TB suspect/case. Fax a completed TB Discharge Treatment Plan (see attachments at the back of this section) to **1.510.628.7898**.

Long-Term Care (Medi-Cal)

The Alliance Medical Services Department will identify, refer, and assist Medi-Cal members in need of long-term care services with transfer into a long-term care facility. Long-term care needs are determined in accordance with the medical criteria delineated in Title 22, California Code of Regulations. These facilities include skilled nursing facilities, subacute facilities, pediatric subacute facilities, and intermediate care facilities. This does not apply to hospice care.

If a member requires long-term care placement that extends beyond the month of admission and the next month, the member will be dis-enrolled from the Alliance, and moved into the Medi-Cal fee-for-service system. This policy applies even when the Alliance is not the primary payer of the first and second month of admission. The Alliance will ensure continuity of care for the member by facilitating this transition with the provider, the member, and the Medi-Cal Field Office.

DOCUMENTATION

Providers must send the Alliance a complete history of the illness including diagnostic tests, procedures, and treatments from all physicians involved in the member's care. Documentation must include a statement from the provider that verifies that the member will be a long-term care resident extending beyond the month following the month of admission.

Providers must complete the Medi-Cal Medical Exception Form and return it to the Alliance Medical Services Department.

Major Organ Transplants (Medi-Cal)

Medi-Cal members identified by Alliance providers as potential candidates for major organ transplant procedures should be promptly referred to Medi-Cal approved transplant centers for evaluation.

Medi-Cal members whose transplant procedures have been authorized by the Medi-Cal Field Office (for adults) or the CCS program (for children) will be disenrolled from the Alliance according to DHCS guidelines.

Medi-Cal members, for whom a transplant procedure authorization is denied, will continue to receive primary care and treatment services from the Alliance. Except for kidney and corneal transplants, major organ transplant procedures for Medi-Cal members are not covered by the Alliance.

The transplant procedures covered under the Medi-Cal fee-for-service program include:

- Bone Marrow
- Liver
- Heart
- Lung

- Lung/Heart
- Liver/Small Bowel
- Small Bowel

APPROVAL AND AUTHORIZATION PROCESS - PCP AND SPECIALISTS

The PCP or attending specialist must send an Alliance Authorization Request to the Alliance Medical Services department for a member seeking evaluation as a potential candidate for a major organ transplant.

Medi-Cal members will be referred to a Medi-Cal approved transplant center for evaluation. During the evaluation process, the Alliance maintains complete responsibility for the medical care of that member.

TRANSPLANT CENTERS

If the Medi-Cal designated transplant center deems the member suitable for transplant, the center must inform the Alliance. The center's physicians are responsible for a Medi-Cal treatment authorization request.

COORDINATION OF CARE

The Alliance Health Care Services Department, in coordination with the PCP, will assure that members receive appropriate referrals for clinical evaluation with specialists, in or outside of the Alliance network.

TRANSPLANT APPROVED

If the member is approved for transplant by the appropriate state office and the Alliance has received supporting documentation, the member will be dis-enrolled from the plan. The Medical Services department will contact the PCP to facilitate the member's transition into care outside of the Alliance.

The effective date of disenrollment will be retroactive to the beginning of the month in which Medi-Cal authorization is given. Services performed after the effective date of disenrollment should be billed fee-for-service through the State Medi-Cal program.

The Alliance contracted PCP and/or specialist is responsible for transferring the member's medical records directly to the new provider once the member has been dis-enrolled from the Alliance.

TRANSPLANT NOT APPROVED

If the member is not approved for the transplant, the Alliance will continue case management of the member in coordination with the PCP for ongoing care. The member's eligibility will continue with the Alliance until the transplant is approved.

Section 13: Health Education

Health education services are important benefits that the Alliance offers to providers and members. This section outlines some of the available services.

Health Education and Programs

The Alliance offers free health education services to Alliance members. Alliance-sponsored classes, materials and self-management programs help members achieve healthy lifestyles, prevent illness and injury, and manage health conditions. The Alliance partners with many local agencies and providers to offer health education services. Programs and handouts are designed to meet the cultural, linguistic and health literacy needs of our members. Providers can find a listing of health education offerings and community referrals in our Provider Health Education Resource Directory on the Alliance website at **www.alamedaalliance.org**.

Alliance Health Programs currently offers the following:

- Handouts on many health topics in English, Spanish, Chinese & Vietnamese
- Interpreter services and transportation for members who attend health education classes sponsored by the Alliance
- Printed and audio/visual health education materials for provider distribution
- Referrals for one-on-one support with diabetes, childhood asthma and breastfeeding
- Referrals to group classes on diabetes, hypertension, CPR/First Aid, weight management, pregnancy/breastfeeding/childbirth, and parenting

There are many ways to request health education services:

- Call Alliance Health Programs at **1.510.747.4577**
- Download materials and forms at www.alamedaalliance.org/live-healthy
- Members can mail or fax the Member Wellness Request Form
- Providers can fax the Provider Wellness Request Form

Our programs often change to ensure we meet the needs of our members and providers. Please contact us to receive the most current information:

Alliance Health Programs
Phone number: **1.510.747.4577**
Email: **livehealthy@alamedaalliance.org**
www.alamedaalliance.org/providers/health-education-and-wellness-resources

Section 14: Serving Your Diverse Population

Alameda County is culturally diverse and residents speak a wide variety of languages. This section will help you provide Alliance members with culturally and linguistically appropriate services.

In accordance with the US code of Federal Regulations, Title 42, CFR Section 440.262, we ask that all Alliance providers to promote access and delivery of service in a culturally competent manner to all patients, including those with limited English proficiency, diverse culturally and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. These methods must ensure that patients have access to covered services that are delivered in a manner that meet their unique needs.

The Alliance is committed to providing services in a member's preferred language, including American Sign Language. This section outlines how language preferences are identified and the requirements for providers with respect to language access and documentation.

TITLE VI COMPLIANCE

Alliance providers must comply with Title VI of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d and 45 C.F.R. Part 80). Title VI prohibits recipients of federal funds, such as, Medicare/Medi-Cal providers, from discriminating against persons based on race, color, or national origin.

In accordance with Title VI, all Alliance providers (PCPs, ancillary, specialty, and in-patient providers) must provide access to services in the member's language at all points of contact, at no time should a provider rely on translation or interpretation services from a member's own family members or friends, unless the member insists, and the use of non-qualified interpreter is documented.

When a member selects a provider who does not speak the member's language, the provider is still obligated to meet the member's language needs in compliance with Title VI by utilizing in-house bilingual and/or bi-cultural staff, using over-the-phone or video interpreter services or scheduling in-person services for ASL, complex or highly sensitive appointments. These services are provided at no cost to the member.

Documenting Staff Language Proficiency

All Alliance providers must keep documentations of the language proficiency for all their clinical and non-clinical employees who are bilingual and communicate with a patient in a language other than English.

Signage for Interpreter Services

Providers should have multilingual signage available for non-English speaking patients. This will help you and your office staff identify which languages Alliance members speak. We can provide you with a sign for use in your office which states: “Point to your language! We will get you an interpreter,” in multiple languages. For a laminated sign, please see Sections 13 attachments or call the Alliance Provider Services Department at **1.510.747.4510**.

If a provider is unable to provide language access for the member through their office’s own resources, the Alliance will assist with interpreter services at no cost to the provider or member. Please refer to “Requesting Interpreter Services” in this section.

QUALIFIED MEDICAL INTERPRETER SERVICES

The Alliance provides interpreter services that include telephonic, video, or in-person interpretation when a provider cannot meet the language needs of an Alliance member. These interpreter services are used during discussions of medical and non-medical information. Hospitals are required to provide interpreter services to patients.

At the time of scheduling the medical appointment, please ask the patient (or minor patient’s parents) what their preferred language is for speaking and for reading. When an Alliance member’s language needs cannot be met by the provider, please offer to arrange for interpreter services. Please document the member's preferred language and any refusal of qualified interpreter services in the medical chart.

Requesting Interpreter Services

The Alliance provides no-cost interpreter services including American Sign Language (ASL) for all Alliance covered services, 24 hours a day, 7 days a week. Please confirm your patient’s eligibility before requesting services.

TELEPHONIC INTERPRETER SERVICES

Common uses for telephonic interpreter services:

- Routine office and clinic visits.
- Pharmacy services.
- Free standing radiology, mammography, and lab services.
- Allied health services such as physical occupational or respiratory therapy.

To access telephonic interpreters:

1. Please call **1.510.809.3986**, available 24 hours a day and 7 days a week.
2. Provide the nine-digit Alliance member ID number.
3. For communication with a patient who is deaf, hearing or speech impaired, please call the California Relay Service (CRS) at **7-1-1.**

IN-PERSON INTERPRETER SERVICES

Members can receive in-person interpreter services for the following:

- Sign language for the deaf and hard of hearing
- Complex courses of therapy or procedures, including life-threatening diagnosis (Examples: cancer, chemotherapy, transplants, etc.)
- Highly sensitive issues (Examples: sexual assault or end of life)
- Other conditions by exception. Please include your reason in the request.

To request in-person interpreters:

1. You must schedule in-person interpreter services at least **five (5) business days** in advance. For ASL, **five (5) days** is recommended, but not required.
2. Please complete and fax the **Interpreter Services Appointment Request Form** to the Alliance at **1.855.891.9167**. To view and download the form, please visit **www.alamedaalliance.org/providers/provider-forms**.
3. The Alliance will notify providers by fax or phone if for any reason we *cannot* schedule an in-person interpreter.
4. If needed, please cancel interpreter services at least **48 hours** prior to the appointment by calling the Alliance Provider Services Department at **1.510.747.4510**.

TRANSLATION OR ALTERNATE FORMAT OF ALLIANCE DOCUMENTS

Members can also request written member materials in a language or format they need. All key Medi-Cal Alliance materials are offered in English, Spanish, Chinese and Vietnamese. Key Group Care materials are offered in English, Spanish and Chinese. Members can call the Alliance Member Services Department to request materials in their preferred language, or materials in an audio, braille, large print or other alternative formats. Professional medical interpreter services, written translation and alternate formats of plan member informing documents are free for Alliance members.

For more information, please call:

Alliance Member Services Department
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**

MATCHING MEMBER AND PRIMARY CARE PROVIDER LANGUAGE

Members may select their PCP by language using the Provider Directory. The Provider Directory identifies the language capabilities available in the provider office. Alliance members are encouraged to choose their own PCP. However, if a member does not choose a PCP, one will be chosen for the member through auto-assignment. If auto-assignment is necessary, the Alliance makes every effort possible to match the member's preferred language with the provider office's capabilities.

Cultural & Linguistic Provider Training & Development

CULTURAL SENSITIVITY TRAINING

All Alliance providers and staff are given information which enables them to complete a sensitivity training during the new provider orientation and again regularly thereafter to keep staff updated on best practices and changing member demographics.

The training includes:

- Cultural competency/sensitivity
- Diversity among the Alliance's member population
- Provider and member resources to include language assistance services and translated materials
- Best practices for providing health care services to members with limited English proficiency, diverse cultural and ethnic backgrounds, senior and persons with disabilities, and diverse gender, sexual orientation or gender identities.

The Alliance's Cultural Sensitivity Training is updated annually and available online at **www.alamedaalliance.org.** Providers can also request a copy by calling the Alliance Provider Services Department at **1.510.747.4510**.

Providers and office staff who need help locating culturally and linguistically appropriate health education materials, can call Alliance Health Programs at **1.510.747.4577**.

Monitoring Cultural & Linguistic Access and Quality of Care

One of the Alliance's goals is to evaluate, implement, and integrate cultural and linguistic competency across plan operations in order to create a culturally competent organization, increase access to care, enhance quality of care and health outcomes, maximize patient satisfaction and retention, and reduce health disparities. Measuring and improving cultural competency is a key factor in reducing socio-cultural barriers to health care. The ultimate goal is to increase quality of care for all Alliance members, with an emphasis on reducing health disparities for our largest ethnic and language groups.

The Alliance monitors cultural and linguistic access and quality of care through member surveys, membership data, claims data, special studies, site reviews, complaint data, and quality indicators.

FACILITY SITE REVIEWS

During PCP and high volume specialist facility site reviews, Alliance staff will evaluate:

- Whether providers are recording the member's preferred language in medical records or on a computerized system.
- The procedures followed when serving a member whose preferred language is not English.
- The provider's system for scheduling members who require interpretation services.

- The availability of patient literature and signs in languages other than English.

REVIEW OF QUALITY INDICATORS

The Alliance examines culture and language as elements in its quality studies. These studies allow the Alliance to identify patterns of use that may indicate unmet cultural and linguistic needs.

For example, a study may ask:

- Are members who speak a primary language other than English less likely to go to an Initial Health Assessment (IHA)?
- Are visits to the emergency room disproportionately high for some populations?
- Are there significant differences in satisfaction rates that can be linked to race, culture or language?

Results are used to help the Alliance and its providers develop services to ensure access for members with cultural and linguistic needs.

Section 15: Transportation Services

This section contains information on the transportation benefits covered by the Alliance.

Transportation Benefits

MEDICAL TRANSPORT SERVICES
Medical transport is transport that is medically necessary.

Benefits include:

- **Emergency Medical Transportation (EMT)** – Ambulance transport to the nearest hospital is covered if the member has reason to believe that the medical problem is an emergency, and that the problem calls for emergency transport. This includes ambulance transport services supplied through the "911" emergency response system.
- **Non-Emergency Medical Transportation (NEMT)** – NEMT includes transportation by ambulance, wheelchair vans, and gurney vans to or from Alliance-covered services and can be used when:
    - Medically needed
    - A member cannot use a bus, taxi, car or van to get to their appointment because they require assistance to travel
    - Is requested by a treating physician; and
    - Approved in advance and arranged by the Alliance's transportation vendor All requests for NEMT require prior authorization (PA). The transportation must be certified as medically necessary by a physician treating the member. Members or providers can request NEMT by faxing the Physician Certification Statement (PCS) form to the Alliance's transportation vendor at **1.877.457.3352** and calling **1.866.529.2128** for assistance at least **seven (7) business days** before the scheduled appointment and as soon as possible in the case of urgent appointments. Hospital discharges must be arranged at least **four (4) hours** in advance. The Alliance will approve only the lowest cost type of NEMT that is adequate for the member's medical need and is available at the service level required.
- **Non-Medical Transportation (NMT)** – NMT includes transportation by public transportation, taxi, or other car to Medi-Cal-covered services can be used when:
    - A member is able to travel without assistance but requires transportation to or from services covered by Medi-Cal; and
    - Approved in advance and arranged by the Alliance's transportation vendor.

Requests for NMT may require prior authorization (PA) but do not require a physician's signature. Members or providers can request NMT by completing the PCS form and faxing it to the Alliance's transportation vendor at **1.877.457.3352** or by calling directly at **1.866.529.2128** to request for services. Hospital discharges must be arranged at least **four (4) hours** in advance. Certain NMT services will require the PCS form to be completed by the member's provider to verify the level of service needed. The Alliance will approve only the lowest cost type of NMT that is adequate for the member's medical need and is available at the service level required.

Section 16: Formulary and Pharmacy Services

This section covers how to obtain pharmacy services for members.

Pharmacy Benefit Manager (PBM) Services

The Alliance subcontracts select pharmacy services through PerformRX LLC (PerformRX), a Pharmacy Benefits Manager (PBM).

PerformRX's role in the Alliance network includes:

- Processing pharmacy claims
- Processing initial prior authorization (PA) and exception requests
- Managing the pharmacy network
- Developing and leading the drug class reviews in the Pharmacy & Therapeutics (P&T) committee meetings
- Monitoring and reporting drug utilization patterns
- Conducting online Drug Utilization Evaluation (DUE) programs at the point of sale

Providers and pharmacies are encouraged to contact PerformRX for questions related to prior authorizations and claim transactions. The most current contact information, operating hours, and operating manual related to PerformRX is located online at **www.alamedaalliance.org**.

Formulary

The Alliance maintains a Formulary (Preferred Drug List) for both Medi-Cal and Group Care members for the outpatient prescription benefit (also known as a retail pharmacy benefit). The Formulary lists drugs available to Alliance members without the need for prior authorization (PA). The Formulary applies to all members except for those assigned to the Kaiser medical group.

The Alliance Medi-Cal formulary is comparable to the Medi-Cal fee-for-service (FFS) Contract Drug List (CDL), except for drugs that are carved out. The Alliance Medi-Cal formulary contains drugs that have the same mechanism of action sub-class within all major therapeutic categories of prescription drugs included in the FFS CDL. However, the Alliance may have different utilization controls for drugs than that of the FFS formulary. The Group Care formulary is exempt from this equivalency standard.

The Alliance Pharmacy and Therapeutics (P&T) Committee is responsible for the development of the Formulary using sound clinical evidence. Therapeutic classes in the Formulary are reviewed at least annually by the P&T Committee. The P&T Committee consists of the Alliance Chief Medical Officer or designee, Alliance Director of Pharmacy, licensed practicing pharmacists, and licensed practicing physicians from the community. The group meets at least quarterly.

Updates to the Formulary are communicated online to both members and providers.

Providers may request changes to the formulary. Request for changes are reviewed during the P&T meeting the following quarter.

The Alliance P&T Committee uses the following criteria in the evaluation of drug selection for its Formulary:

- Drug safety profile
- Drug efficacy
- Drug effectiveness
- Comparison of relevant drug benefits to current formulary drugs of similar use, with a goal of minimizing duplication
- Comparable cost and outcomes of the total cost of drug and medical care

FORMULARY CATEGORIES

There are **four (4)** drug dispensing categories on the Alliance formulary, including restrictions and preferences:

1. **Formulary Drugs**
   Drugs on the formulary are preferred and may or may not require prior authorization (PA) for claim adjudication. When covered, the drugs may also have one or more of the following restrictions:
   - Generic Substitution – The generic equivalent has to be dispensed when available
   - Quantity Limits – A limit on the quantity and/or duration of therapy
   - Step Therapy – Requires one or more of a prerequisite first step drug to be tried before progressing to a second step drug
   - Age/Gender Restriction – Restriction to a specific age or gender when medically appropriate for the drug

   Providers can refer to the comprehensive formulary for further explanation and a list of specific drugs are subject to generic substitution and step therapy, or have quantity limits or age/gender restrictions.

2. **Therapeutic Interchange**
   Therapeutic interchanges promote rational pharmaceutical therapy when evidence suggests that clinical outcomes are comparable when substituting a drug that is therapeutically equivalent but chemically different from the prescribed drug. The substituted drug may be of a different drug class but has comparable effectiveness.

   Therapeutic interchange protocols are never automatic and require authorization from the prescribing provider.

3. **Drugs Requiring Prior Authorization**
   Non-formulary drugs subject to prior authorization requires approval from the Alliance or the PerformRX Authorization Department. The prior authorization review process serves as quality measure to ensure the drug is safe and cost-effective. To review the request, the Alliance and PerformRX uses drug treatment guidelines (criteria), reviewed and approved by P&T.

   If a drug is not listed as covered on the comprehensive formulary, it can be assumed that it requires an authorization or exception.

4. **Drugs Requiring Exception**
   Non-formulary drugs can also be requested and processed as an exception. An exception is similar to a prior authorization except the Alliance does not have drug review guidelines (criteria) to guide the clinical reviewer or the requested drug exceeds the scope of coverage (see Non-Formulary drugs, below). Rather, approval will be based on evidence of medical necessity on a case by case basis.

   The exception review process serves as a quality measure to ensure the drug is safe, cost-effective, and medically necessary. The PerformRX Prior Authorization Department will forward all exception requests to the Alliance to be reviewed by a licensed pharmacist or physician. Providers can request an exception authorization by submitting a Prescription Drug Prior Authorization Request Form to PerformRX per the exception protocols.

   Please contact PerformRX for inquiries on any of the above formulary categories or to submit a verbal or written prior authorization or exception request. The most current contact information is located online at **www.alamedaalliance.org**.

HOW TO ACCESS THE FORMULARY

Providers can access the Alliance formularies on our website at **www.alamedaalliance.org**.

The formulary can also be accessed by using Epocrates®, which provides free mobile and online access. For more information about accessing the Alliance formulary, please visit **www.epocrates.com**.

Pharmacy Prior Authorizations and Exceptions

In some instances, a provider may want to prescribe a drug for a member that is not listed on the formulary, or does not meet a step therapy restriction, quantity limit, or duration of therapy limits (as listed on the formulary). Providers can submit a prior authorization or exception request to obtain coverage for these drugs.

HOW TO REQUEST PRIOR AUTHORIZATION OR EXCEPTION

If a drug is not listed as covered on the comprehensive formulary, it can be assumed that it requires a prior authorization or exception.

Prescribers can be proactive with obtaining a prior authorization (PA) or exception approvals to ensure continuity of care. Prescribers do not have to wait until the claim is rejected at the pharmacy to initiate a request. Once the request is received and approved, an authorization will be entered into the pharmacy claims system. The patient can fill the prescription at any network pharmacy without further involvement by the provider or the pharmacist.

Providers should submit a prior authorization (PA) or exception request using the Prescription Drug Prior Authorization Request Form which is included in Section 15 Attachments & Forms. It is important to document the appropriate clinical information that supports the medical necessity of the requested drug, quantity, refill frequency and/or duration of therapy. A determination decision will be made within regulatory time frames per the member's line of business.

Prior Authorization requests can be submitted by fax to PerformRX at **1.855.811.9329** (24 hours a day, 7 days a week) or by calling toll-free at **1.855.508.1713** (Monday – Friday, 8:30 am – 5:30 pm PST).

PRIOR AUTHORIZATION AND EXCEPTION REVIEW PROCESS

All Prior Authorization (PA) and Exception requests are initially reviewed by PerformRX. Requests that cannot be approved by PerformRX are forwarded to the Alliance clinical pharmacy staff for review.

The Alliance reviews the request against the following resources:

- Evidence of Coverage
- Prior Use of Formulary Alternative
- Drug Request Guidelines (approved by P&T Committee)
- Evidenced-based treatment guidelines
- Medical Director review based on medical necessity
- External specialist review based on medical necessity

PRIOR AUTHORIZATION AND EXCEPTION DENIALS

If a request for a prior authorization (PA) or exception is denied, the member and requesting provider will be notified by mail and have the right to appeal per the Alliance guidelines as described in in Section 19: Grievance and Appeals.

EMERGENCY SUPPLY FOR DRUGS REQUIRING PRIOR AUTHORIZATION

Dispensing pharmacists can dispense up to a **three (3) day** supply of non-Formulary drug(s) using the emergency supply override while waiting to obtain a Prior Authorization (PA). Dispensing pharmacists should only utilize this override for use of alleviation of severe pain and/or treatment of unforeseen medical conditions, which, if not treated immediately, would lead to disability or death.

Pharmacies can enter a universal code in the prior authorization field for the override. For the most current override code, please contact PerformRX or consult the operating manual available online. Use of this code will be monitored.

A Prescription Drug Prior Authorization Request Form must be submitted to PerformRX by the following business day for approval of the balance of the prescription.

Pharmacy Network

The Alliance's pharmacy network includes most retail pharmacies in Alameda County and surrounding areas, in addition to a small selection of specialty pharmacies. The pharmacy network serves both Alliance Medi-Cal and Group Care members.

How to Locate a Network Pharmacy:
To find a nearby Alliance network pharmacy, please visit the Provider section of our website at **www.alamedaalliance.org**.

Carve Outs

MEDI-CAL
Certain medications are excluded from coverage by the Alliance for Medi-Cal members and are instead covered by the Medi-Cal FFS program as a carve-out benefit. The excluded drugs are HIV/AIDS, benzodiazepines, or detoxification treatments, and blood and coagulation factor drugs. The claims and prior authorization (PA) processing for these drugs is managed by Medi-Cal FFS.

The dispensing pharmacy must be a Medi-Cal provider in order to be reimbursed for these drugs. The claim must be submitted directly to Medi-Cal FFS at the point of sale; The Alliance does not bill Medi-Cal FFS on behalf of pharmacies or act as an intermediary processor. Please note Medi-Cal FFS maintains a separate formulary for these drugs. If a drug is not covered, prescribers can submit a PA request using the Treatment Authorization Request (TAR) form to the corresponding Medi-Cal TAR Field Office.

Injectables

SELF-ADMINISTERED
Self-administered injectables are dispensed by specialty pharmacies through the pharmacy benefit. The injectables are managed through the usual formulary management process. The Alliance contracts with select specialty pharmacies to provide most of the self-administered injectables and as such, claims will deny at retail pharmacies unless there is a prior authorization (PA). Some self-administered injectables, like insulin, are listed on the formulary and are handled by retail pharmacies. For the most current specialty pharmacies contact information and the specialty pharmacy restricted drug list, please visit our website at **www.alamedaalliance.org**.

PROVIDER-ADMINISTERED

Provider-administered injectables can be processed as a medical benefit or as pharmacy benefit through the Alliance specialty pharmacies. Injectables procured directly by the provider should be billed directly to the Alliance as a medical claim. Injectables procured through the specialty pharmacies are processed directly through the PBM; providers do not need to submit a separate claim. Providers are encouraged to use the specialty pharmacies to order the available physician-administered injectables (refer to the specialty pharmacy restricted drug list). The specialty pharmacies can deliver directly to providers' offices. For more information on how to order from the specialty pharmacies please visit our website at **www.alamedaalliance.org**.

Section 17: Clinical Laboratory Services

Alliance clinical laboratory services are contracted through Quest Diagnostics, which includes multiple testing sites throughout Alameda County. This section covers how to obtain clinical laboratory services for Alliance members.

Outpatient Laboratory Services

Most outpatient laboratory services must be provided through Quest Diagnostics.

Providers should send members or specimens to Quest Diagnostics for all laboratory testing except:

- Tests that are included in the PCP capitation contract
- Genetic, chromosomal and alpha-fetoprotein prenatal testing
- HIV testing
- Renal tests performed at a dialysis center
- Tests that are provided through alternative sites described in the following pages
- Members who are assigned to Alameda Health Systems Network

QUEST DIAGNOSTICS LAB SERVICES

Quest Diagnostics lab services and programs include:

- 2 to 4 hour STAT testing services
- Quest Express – same day testing service
- Client services available 24 hours a day, 7 days a week,
- Courier service
- Supplies
- Custom ICD-10 Requisition Program

QUEST DIAGNOSTIC LAB SERVICES

For courier service, STAT pickup, or will call, please call **1.800.288.8008**, press **3**.

QUEST DIAGNOSTICS CLIENT/PATIENT LAB SERVICES

Quest Diagnostics representatives are available Monday – Friday at **1.800.288.8008** or at the specific departments listed below:

Client Services (results, specimen request, pricing)
Toll-Free: **1.800.288.8008, press 2**

Client Billing Inquiries 8:30 am - 5:30 pm
Toll-Free: **1.800.288.8008**

Patient Billing Inquiries 9 am - 5 pm
Toll-Free: **1.800.722.8158**

Laboratory Procedures in the PCP Office

ASSIGNED MEMBERS

PCPs may perform certain, specific laboratory tests in their offices. These services need to be documented and submitted to the Alliance. All other tests must be sent to Quest Diagnostics.

NON-ASSIGNED MEMBERS

PCPs who provide laboratory services that are normally capitated to a member who is not assigned to them should submit a FFS claim when:

- The test has received prior authorization
- Providing family planning services
- Diagnosing or treating a sexually transmitted disease
- Providing minors consent services
- The services are for a member not assigned to any PCP

Part 3. Medical Management

Section 18: Medical Management

Measuring and Improving Plan Performance (HEDIS®)

Health Effectiveness Data Information Set (HEDIS®) measures are developed by a national group of health care experts, issued annually and used as a standard across the country. Using HEDIS® measures, the Alliance can compare its performance against other managed care plans. HEDIS® study methodology and results are also validated and audited by an external agency.

HEDIS® studies use data submitted by providers on their claims/encounter forms, and may be supplemented with data retrieved from providers' medical records. The Alliance makes every effort to request records or schedule HEDIS® data retrieval for all studies at the same time and only once each year.

MEDI-CAL QUALITY IMPROVEMENT ACTIVITIES

In addition to HEDIS® measures, the Alliance has several monitoring responsibilities for its Medi-Cal members. The Quality Improvement Program examines data from internal studies in such areas as access (e.g., waiting times for appointments, adequacy of provider network), coordination and continuity of care, utilization, and members' rights.

The results of HEDIS® and internal studies for the plan's Medi-Cal members are the basis of planned quality improvement activities. Mandated by the Federal Balanced Budget Act for Medicaid and Medicare health plans, quality improvement activities are aimed at producing statistically significant and sustained improvement in an important aspect of health care delivery or clinical outcome.

An External Quality Review Organization (EQRO) contracted with the Department of Health Care Service validates the Alliance's quality improvement activities. This external review process may also involve requests for member medical records from providers and/or site visits.

Alliance Measures of Provider Performance

Giving providers feedback about their performance in relationship to their peers has proven to be a powerful tool to move behavior toward the best practice.

Alliance providers allow the plan to use provider performance data in quality improvement activities and to conduct the Alliance Quality Improvement Program.

The Alliance Quality Improvement Program includes systems to recognize providers on the basis of:

- Partnership behaviors that assist the plan in measurement and management of health.
- Clinical practices that are linked to improved health outcomes for members.

The data collected from the claims and encounter data are used to measure a provider's clinical practice. The diagnoses and procedure codes documented on these forms are crucial to accurate profiling. Missing, inaccurate or non-specific codes significantly impact systems such as the reporting of annual HEDIS® measures.

Accurate coding of diagnoses and procedures affects the quality profile.

PROVIDER QUALITY REPORT

As part of the Quality Improvement Program, the Alliance compiles a provider quality report for each PCP undergoing re-credentialing.

The report summarizes a range of provider statistics and activities available from the following areas:

- Member complaints
- Quality reviews
- Utilization management
- Member satisfaction surveys
- Site review score

Care Management Programs

Alliance Care Management Programs coordinate with providers and community partners to improve health outcomes and the integration of care for our members across medical and behavioral health and social services. Care Management Programs address the patient's health care needs across the continuum of care from well-being to end of life, through the identification, assessment, development, and execution of targeted evidence-based individualized care plans.

Program Goals

- Improve health outcomes for the Alliance patient population
- Identify and document measurable member specific health goals and plan of care
- Facilitate coordination of care and services to meet member health needs
- Enhance the patient to provider relationship
- Reduce unnecessary medical utilization
- Avoidance of readmissions

- Avoidable emergency department visits
- Management of chronic conditions

Interventions Include The Following:

- Coordinate with the providers of care about progress towards, or lack thereof, with the plan of care
- Assess member needs through Health Risk Assessments (HRAs)
- Develop individualized care plans that address member health and social needs
- Review and analyze utilization data for opportunities for improved care management and coordination
- Work in partnership with community agencies and health practitioners who provide case/care management and services to our members
- Assist members to obtain measurable health outcome goals through educating and facilitating access to services and community resources
- Select targeted members for specific Care Management Programs through predictive modeling methodologies
- Empower and educate members with resources and information to self-manage their health conditions
- Deliver member-centric coordination of care across the continuum

Programs

- Care Planning Coordination: HRAs & Care Plans
- Complex Case Management (CCM)
- Disease Management
- Integrated Case Management
- Transition of Care

Care Planning Coordination

The Care Planning Coordination program helps members identify their needs and develop a plan for meeting those needs. Members' needs are identified by HRAs, and other member-centric information provided to the Alliance.

Interventions Include, But Are Not Limited To:

- HRAs: Assessment of the member's current health and functional status
- Care plans: Setting individualized goals and interventions
- Self-management tools
- Mailing materials to members based on need
- Member education
- Providing mailed and verbal coaching appropriate for member
- Referrals to other Alliance programs when appropriate
- Coordinated care both within the Alliance and community partners

Complex Case Management (CCM)

The Complex Case Management (CCM) program aims to intensively manage and coordinate care for members who have multiple chronic conditions, require an extensive use of resources, and need help navigating the system to facilitate appropriate delivery of care and services. CCM referrals may originate from any source including, but not limited to, self-referral, caregiver, PCPs or Specialists, discharge planners at medical facilities, health information line referrals for Group Care members, and internal department referrals such as the Alliance UM Department, and the Alliance Member Services Department.

CCM Criteria Include:

- Typically severe degree and complexity of the member's illness.
- Typically intensive level of management necessary.
- Typically extensive amount of resources required for the member to regain optimal health or improved functionality.

The Alliance's goals and intervention schedule for completion shall guide the Care Manager (CM) in managing the case. Additionally, the member shall be provided the name and number of the CM to contact as needed.

The CM will perform the following:

- Evaluate cultural, linguistic needs, preferences, or limitations.
- Evaluate visual and hearing needs, preferences, or limitations.
- Address the availability of caregiver resources and their involvement with the member.
- Address available benefits and any needs for community and financial resources
- Provide the member with available programs, resources and program requirements based upon their and their caregiver's preferences and desired level of involvement in their plan of care.
- Make and follow up on referrals to resources. Follow-up on all referrals will be scheduled at the time of the referral and can be combined as part of the next monthly contact, if not considered urgent.
- Contact the member monthly, at a minimum, or more frequently based on the needs of the member and the referrals made. Each contact includes an assessment of the member's progress towards the goals, evaluation of the barriers to the goals, and adjusting the care plan and its goals, as needed.
- Continually update and evaluate the Care Plan based on the member's need and using information from ongoing screenings and assessments.

Disease Management

The Alliance has **two (2)** dedicated disease management programs based on patient population needs and prevalence. The Pediatric Asthma and Adult Diabetes Disease Management programs aim to improve health status of its participants by fostering self-management skills and providing support and education. Programs provide education, chronic care management, patient activation, and coordination of care. All program interventions are based on data-identified patient needs and are developed using evidence-based practice guidelines and care pathways. Members are identified by claims, pharmacy and lab data, as well as direct referrals from physicians or community partners.

- **Pediatric Asthma Program** – Serves members who are 5 to 11 years of age and identified with asthma based on clinical, pharmacy, and utilization data or direct referral.
- **Adult Diabetes Disease Management Program** – Serves members living with diabetes who are 21 years of age or older and identified based on clinical, pharmacy and utilization data or direct referral.

Diabetes Prevention Program (DPP)

The Diabetes Prevention Program (DPP) is a benefit that helps eligible members adopt healthy habits, lose weight, and significantly decrease their risk of developing type 2 diabetes.

Eligibility

- Patient must be 18 years of age or older;
- Overweight; and
- At-risk for type 2 diabetes.

Program Details

- First year includes16 weekly sessions, followed by monthly sessions for the remainder of the year.
- A lifestyle health coach to help set goals and keep participants on track.
- Support groups.
- Second year includes monthly sessions if the member achieves attendance and weight-loss goals.

Alliance members can choose from in-person or digital program formats. For more details on program eligibility or to view and download the referral form, please visit **www.alamedaalliance.org/providers**.

Members can also self-refer by calling the Alliance Member Services Department at **1.510.747.4567** or visiting **www.alamedaalliance.org/live-healthy/dpp** to take a risk quiz and enroll. The DPP curriculum is approved by the Centers for Disease Control and Prevention (CDC).

Health Homes Program (HHP)

HHP is a Medi-Cal benefit covered by the Alliance for members who have certain chronic conditions. These services help them get the care they need to stay healthy.

To receive HHP services, your patient must:

1. Have Medi-Cal coverage and be enrolled with the Alliance.
2. Have certain chronic health conditions (such as asthma, diabetes, kidney or liver disease, heart failure, etc.).
3. Have been in the hospital, had visits to the emergency department, or be chronically homeless.

The Interventions Highlight

People who join HHP are given a care team in the community that may consist of a community health worker supported by a nurse, social worker, or housing navigator that help the member:

- Find doctors and get appointments
- Coordinate the care they receive from different providers
- Understand their prescription drugs
- Get follow-up services after they leave the hospital
- Connect to community and social services, such as food and housing

As a provider, you can ***advise*** your patient to call:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

For more information, please visit **www.alamedaalliance.org**.

You can also ***refer*** your patient by contacting:

Alliance Case and Disease Management Department
Monday – Friday, 8 am – 5 pm
Toll-Free: **1.877.223.6143**
Email: **healthhomes@alamedaalliance.org**

For more information, please view the following resource:
www.dhcs.ca.gov/services/Documents/MCQMD/HHP_Provider_Guide_2019.pdf

Integrated Case Management

The Integrated Case Management program addresses basic case management needs of members.

Staff will work with the member and/or caregiver and their PCP to ensure that needs are addressed and met by doing the following:

- Provide education to gain self-management skills
- Eliminate barriers to care
- Tailor member-centric individualized care plans
- Connect members to their health care providers or services
- Conduct periodic assessments of stability and functioning, medication management, and link to resources and treatment needs.

Members can be referred for case management based on risk profiling or after a transition in care event from the Alliance Utilization Management (UM) Department, Care Advisor Unit, the Alliance Member Services Department, their practitioner, or caregiver. Members who receive integrated case management services may be enrolled in other programs based on need. Referrals may originate from any source including, but not limited to, self-referral, caregiver, PCPs or Specialists, discharge planners at medical facilities, health information line referrals for Group Care members and internal department referrals such as the Alliance UM Department, and the Alliance Member Services Department.

Transition of Care

The Transition of Care program is designed to mitigate any clinical issues a patient may have in the crucial **30 days** post discharge for an admission and emergency department visit.

The Interventions Highlight

- Connecting the patients to their Alliance PCPs, including facilitating discharge follow-up appointments
- Coordination of care services
- Providing education and symptom management
- Facilitating necessary referrals

How to Refer to Members Alliance Programs:

Phone Number: **1.877.251.9612**
Fax: **1.510.747.4130**
Referral form: **www.alamedaalliance.org/providers/medical-management/case-and-disease-management-program**

Reporting Provider-Preventable Conditions

BACKGROUND

Beginning July 1, 2012, federal law requires that all providers report provider-preventable conditions (PPCs) that occurred during treatment of Medi-Cal patients. Providers must report all PPCs that are associated with claims for Medi-Cal payment or with courses of treatment given to a Medi-Cal patient for which payment would otherwise be available.

Providers do not need to report PPCs that existed prior to the provider initiating treatment for the beneficiary.

The Federal Affordable Care Act section 2702 and Title 42 of the Code of Federal Regulations, sections 447, 434 and 438 also require that Medi-Cal and Medi-Cal Managed Care plans no longer reimburse providers for PPCs that occur during treatment of Medi-Cal patients. The Alliance will investigate all reports of PPCs, including those it discovers through any means, to determine if payment adjustment is necessary.

Interested providers may read the State Plan Amendment for PPCs, which took effect July 1, 2012.

REPORTING REQUIREMENTS

For Alliance Medi-Cal members, providers must report directly to the Alliance using the PPC reporting form within **five (5) working days** of discovery of the PPC and confirmation that the patient is a Medi-Cal beneficiary. The PPC reporting form is attached and instructions for completing the form are included.

Please submit forms to:

Alliance Compliance Department
Fax: **1.510.373.5999**
Email: **compliance@alamedaalliance.org**

Please note that reporting PPCs for a Medi-Cal beneficiary does not preclude the reporting of adverse events and healthcare-associated infections (HAI) to the California Department of Public Health pursuant to Health and Safety Code.

Section 19: Grievance and Appeals

The Alliance maintains a Grievance and Appeals process under which members may submit their grievance or appeal to the Alliance in accordance with state and federal regulations. Providers are to comply with the grievance and appeals process in accordance with their contract.

DEFINITIONS

Grievance – A written or oral expression of dissatisfaction with regards to the Alliance and/or provider, including quality of care concerns, and shall include a complaint, dispute, and request for reconsideration or appeal made by a member or the member's representative. Where the Alliance is unable to distinguish between grievance and an inquiry, it shall be considered a grievance.

Prior Authorization (PA) Appeal – A request to change a prior authorization adverse determination for care or service that the Alliance must approve, in whole or in part, in advance of the member obtaining care or services.

Retro Authorization Appeal – Is a request to change a prior authorization adverse determination for care or services that have already been received by the member.

Expedited Review – Cases that involve an imminent and serious threat to the health of the patient, including but not limited to, severe pain, potential loss of life, limb, or major bodily function.

MEMBER GRIEVANCE PROCESS

A member may file a grievance **at any time** following any incident or action that is subject of their dissatisfaction for Medi-Cal members and within **180 calendar days** following any incident or action that is subject of their dissatisfaction for Group Care members.

The Alliance is responsible for processing and resolving all grievances.

When a provider has become aware that a member is dissatisfied with the delivery of care that has been provided, please provide the following information to the member:

- The member can call the Alliance Member Services Department at **1.510.747.4567** and state that they would like to file a grievance; and
- Contracted provider's office or facility are required to make grievance forms and assistance readily available in accordance with California Code of Regulations, Title 28 §1300.68 (b)(7).

In order to provide excellent service to our members, the Alliance maintains a process by which the member can obtain thorough investigation and timely resolution of their grievances with the following process:

- The receipt of the complaint, in writing or by telephone will be acknowledged within **five (5) calendar days**;

- Thorough research and investigation in addition to compiling all applicable information pertinent to the complaint;
- Member/provider education on the policy and procedures of the Alliance when applicable; and
- Timely resolution within **30 calendar days** or **72 hours** if expedited criteria is met.

A member who files a grievance may not be discriminated against, and cannot be dis-enrolled from the provider's office or facility in retaliation of filing a grievance.

As part of the Alliance's investigation, the provider will be required to respond in writing to the complaint and provide medical records if applicable. Written responses are to be received within **ten (10) calendar days** for standard and **24 hours** for expedited cases or if otherwise specified in the request.

MEMBER AUTHORIZATION APPEAL PROCESS

A provider may submit a prior authorization (PA) appeal on behalf of a member for prior and retro authorizations. Please provide the Alliance Grievance and Appeals Department with a copy of the authorization, denial notification, and all pertinent supporting documentation within **60 days** from the date of denial for Medi-Cal members and **180 days** from the date of denial for Group Care members.

The appeal will be acknowledged in writing within **five (5) calendar days** and resolved within **30 calendar days**. If you request an expedited appeal and expedited criteria is met, the member will be mailed a written notice within **72 hours**.

Please mail or fax all information to the contact below:

Alameda Alliance for Health
1240 South Loop Road
Alameda, CA 94502
Phone Number: **1.510.747.4567**
Fax: **1.877.748.4522**
Attn: Grievances and Appeals Department

MEMBERS RIGHTS

The member has the right to contact the Department of Managed Health Care (DMHC) and request an Independent Medical Review (IMR). Members may request an IMR if they have not initiated a State Fair Hearing (Medi-Cal only) and if the member has already completed the Alliance's grievance process. They may contact the DMHC Health Maintenance Organization (HMO) Help Center for further information at **1.888.HMO.2219** (**1.888.466.2219**) or TDD: **1.877.688.9891**.

The Help Center is open 24/7 at no charge to the member. For complaint forms and instructions, please visit the Department's website at **www.hmohelp.ca.gov**.

The member may also contact DMHC if they have a grievance about an emergency, a grievance that has not been appropriately resolved by the Alliance, or a grievance that has not been resolved for more than **30 calendar days** for a standard complaint, and **72 hours** if expedited criteria were met.

Medi-Cal members have the right to file a State Fair Hearing with the California Department of Social Services, State Hearings Division. They may contact the State Hearings Division for further information at **1.800.952-5253** or TDD at **1.800.952.8349**. Medi-Cal beneficiaries may also request a State Fair Hearing through the Alameda County Social Services Agency. State Fair Hearings must be requested within **120 calendar days** from the date of the "Notice of Appeal Resolution".

Medi-Cal members can also contact the Medi-Cal Managed Care Division Office of the Ombudsman to assist with enrollment and other problems.

Monday – Friday, 8 am – 5 pm; excluding holidays,
Toll-Free: **1.888.452.8609**
Email: **MMCDOmbudsmanOffice@dhcs.ca.gov**

Section 20: Credentialing

All healthcare providers who contract with the Alliance must have credentials verified through the credentialing process. This section covers the credentialing and re-credentialing requirements providers are expected to meet.

Credentialing Process

The Alliance utilizes a credentialing process in order to ensure the participation of quality network providers. The Alliance follows National Committee on Quality Assurance (NCQA) guidelines in conjunction with special credentialing guidelines required by State regulation and policy.

DEPARTMENT OF HEALTH CARE SERVICES (DHCS) APL17-019

On November 14, 2017 DHCS released a new All Plan Letter (APL) 17-019, Subject: Provider Credentialing/Re-credentialing and Screening/Enrollment. In this APL17-019 DHCS requires that "all" Managed Care Plan network providers must enroll in the Medi-Cal Program no later than 12/31/2018. In APL17-019 the Alliance is required to perform pre- and post- enrollment site visits to medium and high risk providers to verify the information on the application (i.e., comprehensive outpatient rehabilitation facilities, hospice and home health organizations, independent diagnostic laboratories, independent diagnostic testing facilities, durable medical equipment suppliers, and prosthetic and orthotic suppliers for initial and re-credentialing applicants).

CONFIDENTIALITY

The information obtained during the credentialing process, whether directly from the provider, or from another source, will be treated as confidential information.

THE APPLICATION

Applicants must submit a signed application and supporting documentation to the Alliance. The Alliance then has **180 days** from the signature date on the attestation form to work with the applicant and PRCC to complete the credentialing process.

As part of the application process, providers will be asked to attest to statements regarding:

- Reasons for any inability to perform the essential functions of the position, with or without accommodation
- Lack of present illegal drug use
- History of disciplinary actions taken against the license
- History of loss of license
- History of convictions
- History of loss or limitation of privileges or disciplinary activity at a facility

- History of professional liability judgments and/or claims that resulted in settlements or judgments paid by or on behalf of the applicant, or pending lawsuits
- Current malpractice insurance coverage

ADDITIONAL CREDENTIALING STEPS

Facility Site Review

All PCPs and OB/GYN practice sites are reviewed by an Alliance Provider Services Representative and Quality Improvement Nurse Specialists prior to approval as an Alliance provider. (Please see Section 21 – Facility Site Reviews for detailed information on site reviews.)

Recommendation by the PRCC

The PRCC is a standing Alliance committee responsible for peer review and credentialing/re-credentialing.

The PRCC recommends acceptance or denial of an applicant as follows:

- If the recommendation is for **DENIAL**, the applicant receives written notification of the decision and supporting reasons. If the denial is due to medical quality of care, the appeal process is included.
- If the recommendation is for **APPROVAL**, the applicant receives written notification of the decision and the name and specialty are forwarded to the Board of Governors in the credentialing summary.

Practitioner Rights

Practitioners have the right to review information submitted to support their credentialing application, correct erroneous information, receive the status of their credentialing or re-credentialing application, upon request, and receive notification of these rights. Practitioners are notified of these rights in the application cover letter.

Practitioners are allowed access to their credentialing documentation obtained by the Alliance Credentialing Department to evaluate their credentialing application, attestation, or curriculum vitae (CV) with the exception of National Practitioner Data Bank Reports, references, recommendations, or other peer-review protected information.

Practitioners are notified when credentialing information obtained from other sources varies substantially from that provided by the practitioner. Examples of the type of information that would cause the Alliance to alert the practitioner, if there are substantial variations from the practitioner's information include actions on a license, malpractice claims history, and/or board certification decisions.

The Alliance Credentialing Department staff will contact the practitioner via written request (email or certified mail) of the discrepancy and the practitioner will be asked to submit corrections/explanations within **15 business days** by mail or fax to the Alliance Credentialing Department staff contact.

Right to receive status: Practitioners may contact the Alliance Credentialing Department at any time regarding the status of their application for appointment or reappointment. All such requests will be responded to within **four (4) business days** and the practitioner will be notified of phase in the credentialing process.

Credentialing Criteria and Basic Qualifications

The following credentialing criteria are reviewed at initial credentialing and re-credentialing.

LICENSE

All providers must maintain a current license, which is applicable to the provider's scope of practice in the state of California. If providers have, or had, out-of-state licenses, the status of these licenses shall also be verified for the same qualifications. All initial providers must have an unrestricted license. All provider Medical Board actions are reviewed by the PRCC.

HOSPITAL ADMITTING PRIVILEGES

All providers must maintain current hospital admitting privileges with unrestricted clinical privileges, at a hospital in the Alliance network. The Alliance may waive this requirement if the provider has admitting arrangements in writing through another provider in the Alliance network.

DEA CERTIFICATION

All providers must maintain a current Drug Enforcement Administration (DEA) certification, if applicable to the provider's scope of practice. The Alliance may waive this requirement if the provider's DEA is pending and presents documented evidence that another participating provider will write all prescriptions that require a DEA.

SPECIALTY BOARD CERTIFICATION

Specialists applying to the network must be board-certified in the specialty and sub-specialty effective July 1, 2003, unless the provider was contracted with the Alliance prior to July 1, 2003. Specialists who have recently completed postgraduate training may be credentialed and will be expected to complete their board certification within the timeframe as set forth by the American Board of Specialties.

NPDB and HIPDB

The National Practitioner Data Bank (NPDB) checks medical malpractice claims and license status for any state in which the physician has practiced. The Healthcare Integrity Protection Data Bank (HIPDB) collects information regarding licensure and certification actions, exclusion from federal and State health care programs, criminal convictions, and civil judgments related to health care.

PROFESSIONAL LIABILITY CLAIMS HISTORY
Information related to malpractice suits and settlements will be collected and reviewed.

CLEAR FROM SANCTIONS
The Alliance does not contract with providers who have elected to "Opt Out" of Medicare or are excluded or sanctioned from participation in Medicare/Medicaid programs.

PROFESSIONAL LIABILITY INSURANCE
All participating provider must maintain professional liability insurance with limits of liability of at least $1,000,000 per occurrence and $3,000,000 aggregate at all times.

WORK HISTORY
All providers will be reviewed for work history as obtained through their submitted application or CV.

Re-Credentialing

Participating providers are re-credentialed in accordance with Alliance policy. Currently re-credentialing occurs at least every **three (3) years** or more often as directed by the PRCC. The process is similar to the initial credentialing process as outlined earlier in this section.

The following performance areas will be reviewed for all providers, as applicable:

- Member complaints/grievances
- Results of quality reviews
- Facility site review results

DENIED RECREDENTIALING
If the PRCC determines that a provider does not meet re-credentialing criteria, the provider's participation will be terminated pursuant to the terms of the provider service agreement. From that time onward, the provider may not submit claims to the Alliance for health services provided to Alliance members.

Section 21: Facility Site Review

All Alliance PCPs and OB/GYN providers will receive periodic facility site reviews. This section covers what to expect during a site review.

Facility Site Review Overview

DHCS mandates initial and periodic Facility Site Review (FSR) and Medical Record Review (MRR) audits. The Alliance complies with the DHCS mandate, and audits PCPs, high-volume specialists and OB/GYN provider sites.

The purpose of FSRs is to ensure that all contracted primary care physician sites:

- Provide appropriate primary health care services to members
- Carry out processes that support continuity and coordination of care
- Maintain patient safety standards and practices
- Operate in compliance with all applicable local, State and federal laws and regulations

FSRs are conducted during the initial provider credentialing process. Additionally, site reviews will be conducted as part of the ongoing provider re-credentialing process. This process ensures that each provider continues to meet the Alliance's site review standards. The Alliance Quality Improvement Department is responsible for conducting site reviews.

SITE REVIEW PREPARATION

The Alliance will help providers prepare for the review in several ways. Prior to a review, providers will receive a copy of the site review tool (please see Site Review Tool in the Attachments & Forms section). Providers should review it carefully so that nothing in the site review comes as a surprise. Facility Site Review Nurses offer on-site training prior to initial facility site reviews or upon the provider's request.

The Alliance has developed the Facility Site Review and MRR Provider Toolkit to assist you in meeting the standards of the FSR. We distribute the Toolkit to newly contracted providers and upon request. The Toolkit contains many of the templates and resources needed for provider offices to successfully meet the FSR/MRR criteria. For help preparing your practice for the FSR, call the Alliance Provider Services Department at **1.510.747.4510**.

PROBLEMS FOUND THROUGH FACILITY SITE REVIEWS AND MEDICAL RECORD REVIEWS

If a facility is found to be out of compliance with Alliance and/or State requirements, the provider is notified through the Corrective Action Plan (CAP). For MRRs, a CAP is required for any score below 90% or any section score below 80% regardless of total score. A total score under 80% will result in a hold on new member assignment.

Participation in the Alliance network may be suspended until the facility meets compliance standards. If a provider's non-compliance issues present a clear and immediate danger to patients, the provider's members will be re-assigned to another provider in the Alliance network. If problems are documented, providers are allowed time for correction. Problems must be corrected within **45 days** of receipt of the CAP. Failure to provide a timely response will result in a re-survey within **12 months** and/or reporting the provider's site review status to the Alliance's PRCC. The PRCC may suspend a provider from plan participation, or recommend termination due to non-compliance to the Alliance Board of Governors.

PROBLEMS FOUND THROUGH DHCS FACILITY REVIEWS

DHCS conducts facility site reviews independently of the Alliance on a small sample of the Alliance's provider network. DHCS does this to monitor the Alliance's compliance with the DHCS contract and to determine how well provider sites are able to implement and meet the standards. Should a DHCS inspector find a primary care site in substantial non-compliance, the Alliance may suspend that site from plan participation until the facility can meet compliance standards. If the provider's non-compliance issues present a clear and immediate danger to Alliance members, they will be reassigned to another provider in the Alliance network. An MRR with a score below 80% will result in a follow-up MRR in **six (6) months** and a hold placed on new membership assignment.

Facility Site Reviews (FSR)

The Alliance's Facility Site Review (FSR) and MRR Provider Toolkit contain essential tools, templates, and guidance for meeting the standards of the survey.

To request a Provider Toolkit, please contact the Alliance Provider Services Department at **1.510.747.4510**

FACILITY SITE REVIEW TOOL

The Alliance utilizes a facility site review tool mandated by DHCS. A copy of the full FSR Tool is included in the FSR and MRR Provider Toolkit in the back of this section. For OB/GYN specialist, a modified FSR tool is used. The tool contains applicable State requirements. The site review tool mandates review in the broad areas listed below.

Please see the full FSR Tool for a detailed explanation of the **eight (8)** criteria listed below:

1. Site Access/Safety
2. Site Personnel
3. Office Management
4. Preventive Service
5. Infection Control
6. Clinical Services
7. Pharmaceuticals Laboratory
8. Radiology

Any deficiency found in the infection control and pharmaceutical services sections of the survey requires a corrective action plan regardless of score.

CRITICAL ELEMENTS

Within the Facility Site Review, there are **nine (9)** critical survey elements related to the potential for adverse effects on patient health or safety. These critical elements have a weighted score of **two (2)** points. All other survey elements are weighted at **one (1)** point. Critical elements include:

1. Exit doors and aisles are unobstructed and egress accessible.
2. Airway management equipment (i.e., oxygen delivery system, oral airways, nasal cannula or mask, ambu bag) appropriate to practice and populations served are present on-site.
3. Only qualified/trained personnel can retrieve, prepare, or administer medications. Medical assistants must be supervised by licensed personnel in retrieving and preparing medications prior to administration.
4. Office practice procedures utilized on site provide timely physician review and follow-up of referrals, consultation reports and diagnostic test results.
5. Only lawfully authorized persons dispense drugs to patients.
6. Personal protective equipment (PPE) is readily available for staff use.
7. Needle stick safety precautions are practiced on site.
8. Blood, other potentially infectious materials, and regulated wastes are placed in appropriate leak-proof, labeled containers for collection, processing storage, transport or shipping.
9. Spore testing of autoclave/steam sterilizer is completed (at least monthly) with documented results.

CRITICAL ELEMENT DEFICIENCIES

All critical element deficiencies found during a full scope site survey, focused survey, or monitoring visit must be corrected by the provider within **10 business days** of the survey date, and verified as corrected by the plan within **30 calendar days** of the survey date. Any critical element found deficient must be corrected to 100%.

HELPING PROVIDERS MEET STANDARDS

Sites that are non-compliant with the Alliance and/or State requirements are given a **45 day** period to correct identified deficiencies.

The Alliance wants to help all of our providers meet the standards. The Alliance Provider Services Department staff and FSR nurses offer guidance and training, or refer providers to resources that can help them meet the established standards.

Medical Record Reviews

The Alliance's FSR and MRR Provider Toolkit contain essential tools, templates, and guidance for meeting the standards of the survey.

To request a Provider Toolkit, contact the Alliance Provider Services Department at **1.510.747.4510**.

MEDICAL RECORD REVIEW SURVEY

The Alliance utilizes an MRR tool mandated by DHCS. The MRR Survey is a separate tool from the FSR Tool.

A copy of the full MRR Survey is included in the FSR and MRR Provider Toolkit and back of this section. For OB/GYN specialists, a modified MRR tool is used. The tool contains applicable State requirements, as well as some additional Alliance standards. The MRR Toolkit mandates review in the broad areas listed below. Please see the full MRR Survey for a detailed explanation of the **six (6)** criteria listed below:

1. Format
2. Documentation
3. Coordination/Continuity of Care
4. Pediatric Preventive Health Care
5. Adult Preventive Health Care
6. Obstetric/Comprehensive Perinatal Services Program (OB/CPSP) Preventive Criteria

Alliance providers are required to have a medical record for each member. During an MRR, a minimum of **10** member records are audited per contracted provider. Reviewers may request additional records.

HELPING PROVIDERS MEET STANDARDS

The Alliance wants to help all of our providers meet the standards. The Alliance Provider Services Department staff and FSR nurses offer guidance and training, or refer providers to resources that can help providers meet the established standards. To request assistance, please call the Alliance Provider Services Department at **1.510.747.4510**, or FSR representative at **1.510.747.6169**.

Provider Initial Review and Fair Hearing Process

Physicians, ancillary professionals, and other providers shall be entitled to an Initial Review or Fair Hearing and Appeals proceedings when dissatisfied with certain adverse credentialing and/or participation decisions made by the Alliance, including those based on a medical quality concerns.

The Initial Review and Fair Hearing process is divided into **two (2)** phases:

- Phase I – Initial Review: An Initial Review before the PRCC to try to amicably resolve the matter; and

- Phase II – Formal Hearing: For Providers who are dissatisfied with the PRCC Initial Review decision and eligible for a Phase II hearing, a formal hearing in front of an impartial Judicial Review Committee (JRC).

PROCEDURES FOR INITIAL REVIEW

The Alliance offers providers an Initial Review when the provider is dissatisfied with an adverse credentialing and/or participation decision made by the PRCC. Decisions may include recommendations, such as, practice restrictions, denial of application, or participation in the Alliance network.

The provider will be notified in writing of the PRCC decision. The provider may request an Initial Review within **30 days** of receipt of the notice of action or proposed action by PRCC. A request for Initial Review must be in writing and must state the basis for the challenge, whether the provider would like to present evidence or oral testimony to the PRCC, or both, whether the provider needs special accommodations, and any preferred time or dates for the Initial Review within the next **60 days**.

The following procedures are followed for Initial Reviews:

- All credentialing and peer review issues shall be brought before the PRCC for review and recommendation.
- Notice will be given to the provider stating the date of the initial review meeting and the provider shall have an opportunity to present their position.
- The decision of the PRCC shall be binding and final if the decision was for any reason other than medical quality of care concern.
- If a decision of the PRCC is based in whole or in part on medical quality of care concerns, the provider shall have the right to appeal the PRCC decision to an impartial JRC through the Fair Hearing process.

FAIR HEARING PROCESS

Providers may request a Fair Hearing who are dissatisfied with the PRCC Initial Review decision and are eligible for a Phase II hearing, a formal hearing in front of an impartial JRC.

GROUNDS FOR A FAIR HEARING

One or more of the following actions, or proposed actions, against a provider by the PRCC after the Initial Review shall be grounds for a formal hearing before the a JRC:

- Upholding the Alliance's reduction or failure to renew credentialing and/or participation based on Medical Quality Concerns;
- Upholding the Alliance's suspension or imposition of restrictions on credentialing and/or participation for a cumulative total of **30 calendar days** or more in any **12 month** period based on Medical Quality Concerns;
- Upholding the Alliance's denial or termination of credentialing and/or participation based on Medical Quality Concerns.

Requesting an Appeal

If the PRCC recommends an adverse decision based on medical quality concerns of an initial application or re-credentialing that result in a mandatory reportable action, the practitioner will be notified in writing of this decision. The practitioner has the right to request a hearing before a JRC within **30 days** of receipt of the PRCC notification. A provider who wishes, and is eligible, to file an appeal of an adverse credentialing or participation decision must deliver a written notice requesting a fair hearing before the JRC to the Alliance Chief Medical Officer within the time period specified.

The following procedures are followed for a Judicial Review process:

- Fair Hearings shall be brought before a JRC for review and recommendation.
- Notice will be given to the provider stating the date of the JRC and the provider shall have an opportunity to present their position.
- The decision of the JRC will be sent to the PRCC and the practitioner.
- The JRC will issue a written decision which shall include findings of fact and a conclusion within **30 calendar days** after final adjournment of the hearing.

Requirements for Mid-Level Clinicians

REQUIREMENTS FOR MID-LEVEL CLINICIANS

PCPs that employ or contract with mid-level clinicians in their practices are responsible for making sure that the clinicians meet the standards set forth by the clinician's licensing authority. The PCP, as the clinician supervisor, is also responsible for developing the protocols under which the clinician will practice. They must meet certain qualifications and standards in order to be credentialed by the Alliance. This helps ensure quality care for members.

DEFINITIONS OF MID-LEVEL CLINICIANS

Mid-level clinicians are non-physician medical practitioners, including:

- Nurse Practitioners
- Physician Assistants
- Certified Nurse-Midwives

CREDENTIALING

Any mid-level clinician that provides care to Alliance members must be credentialed by the Alliance.

LICENSING REQUIREMENTS

To provide services to Alliance members, mid-level clinicians must have a valid, current license issued by the state of California. Nurse-midwives must be certified by the ACNM Certification Council, Inc. Physician Assistants must be licensed in accordance with the requirements of the Physician Assistant Examiners Committee.

INSURANCE
The supervising physician must submit proof that their liability insurance covers the mid-level clinician, or that the clinician has individual coverage.

CPR AND ACLS CERTIFICATION
Mid-level clinicians must maintain CPR certification. They also are encouraged to obtain ACLS certification.

PHYSICIAN/CLINICIAN AGREEMENT
Each physician/mid-level clinician team must sign an agreement stating that the clinician will follow the practice protocols developed by the supervising physician. The agreements, also known as a Delegated Services Agreement and a Supervising Physician's Responsibility document, must be submitted at the time of credentialing and re-credentialing.

PROTOCOLS
Protocols must be reviewed and approved by the supervising physician annually. These protocols and any updates must be submitted to the Alliance at the time of credentialing and site reviews.

Organizational Providers

The Alliance is responsible for verification of the accreditation status, license, certification and standing with regulatory bodies of all directly contracted organizational providers. This includes, but is not limited to, acute care hospitals, free standing surgical centers, home health agencies, and skilled nursing homes that provide care to Alliance members, at the time of contracting and at a minimum every **three (3) years** thereafter.

Hospitals, facilities, and organizational providers must meet the following requirements to contract with the Alliance by submitting all licensing and specialty qualification documents to the Alliance for verification as part of the Alliance credentialing and re-credentialing Process and demonstrating the ability to meet Alliance requirements as outlined in the Alliance Quality Improvement Plan, Assessment of Organizational Provider Policy, and contract provisions.

REQUIREMENTS
- Completed Alliance application including attestations.
- Valid, current and unrestricted healthcare/state and business licenses.
- Valid and current Medicare/Medicaid certification.
- Eligibility to participate in State and federal programs.
- Current malpractice/general professional liability insurance.
- Accreditation or certification reviewed and approved by an accrediting body. If not accredited, the organization must submit copy of CMS or state site survey.
- Clear of any sanctions, negative findings, or deficiencies.
- Clinical Laboratory Improvement Amendment (CLIA) certificate, if applicable.

Part 4. Member Rights & Compliance

Section 22: Member Rights and Responsibilities

As a member of our health plan, each Alliance member is entitled to certain rights.

Alliance Members' Rights

1. To receive information and advice about the Alliance, its programs, its doctors, the health care network, Advance Directive, and their rights and responsibilities.
2. To receive services and care without discrimination of race, color, ethnicity, national origin, religion, immigration status, age, disability, socioeconomic status, gender identity, or sexual orientation.
3. To be treated with respect at all times.
4. To choose a PCP within the Alliance's network and help make choices about their health care with their doctor.
5. To talk freely with their doctors about treatment options for their health and help make choices about their health care with your doctor, this includes the right to refuse treatment.
6. To voice complaints (grievance) about the Alliance, its doctors, or the care the Alliance provides, or ask for a State Medi-Cal Fair Hearing.
7. To receive translation and interpreter services and written information in other formats (audio, braille, large size print, etc.).
8. To access covered Federally Qualified Health Centers, American Indian Health Programs, sexually transmitted disease services, emergency services and family planning services outside the Alliance's network, Minor Consent Services, and specialty services (i.e., Durable Medical Equipment (DME)).
9. To leave the Alliance upon request at any time, subject to any restricted disenrollment period.
10. To continue to see their doctor if you are no longer covered by the Alliance under certain circumstances.
11. To be free from any form of restraint or rejection used as a means of pressure, discipline, convenience, or retaliation.
12. To use these rights freely without changing how they are treated by the Alliance, doctors, the health care network, or the State.
13. To access the Alliance Nurse Line, 24/7 at **1.888.433.1876**.

14. To access telephone triage or screening 24/7 by calling their PCP.

Alliance Members' Responsibilities

The Alliance is responsible for providing members with access to medically necessary covered services in a timely manner. Alliance members have certain responsibilities as well.

1. To treat all the Alliance staff and health care staff with respect and courtesy.
2. To give their doctors and the Alliance correct information.
3. To work with their doctor. Learn about their health, and help to set goals for their health. Follow care plans and advice for care that they have agreed to with your doctors.
4. To always present their Alliance Member Identification Card to receive services.
5. To ask questions about any medical condition, and make sure they understand their doctor's reasons and instructions.
6. To help the Alliance maintain accurate and current records by providing timely information regarding changes in address, family status, and other health care coverage.
7. To make and keep medical appointments and inform their doctor at least 24 hours in advance when they need to cancel an appointment.
8. To use the emergency room only in case of an emergency or as directed by their doctor.

How to Protect the Protected Health Information (PHI) of Your Patients

As you are well aware, protecting the privacy of patients and their Protected Health Information (PHI) is a responsibility we all share. The Alliance is committed to protecting every member's PHI that we have and we want to insure that you do too!

The Health Information Portability and Accountability Act (HIPAA) clearly outline how providers can use and disclose PHI. Additional federal and California state laws have been enacted governing the release of information, mandating that information be protected, creating new breach notification rules, and setting civil and criminal penalties and fines for the inappropriate release of PHI.

Written patient permission is required for most uses and disclosures of PHI. The exceptions generally are that PHI may be used and disclosed for the purpose of treatment, payment, and health care operations (and a few other specific exceptions).

What can you and your office do to protect member privacy?

- Keep PHI actively in mind and in your policies amongst your staff.
- Provide training for yourself and for staff about privacy.
- Develop a process to respond to privacy issues that arise (including notifying the Alliance of any breach).

- Limit transporting PHI out of your office.
- Use secure email when communicating about members with someone outside your office.
- Store and lock up records and documents containing PHI.
- Secure your office computers from unauthorized access.
- Shred physical documents that contain PHI when no longer needed.
- Keep appointment and registration sheets away from public view.
- Don’t text PHI.

For more information about PHI and HIPAA compliance, please visit **www.hhs.gov**. If you have questions about how to improve the security and storage of member PHI, or would like a copy of the privacy practices, please call the Alliance Provider Services Department at **1.510.747.4510**.

Section 23: The Alliance Compliance Programs

This section describes guidelines that the Alliance has for providers to use for preventing and reporting fraud, waste, and abuse and Protected Health Information (PHI).

Fraud Prevention Program Overview

The Alliance has developed an Anti-Fraud Program to comply with federal and State regulations in preventing and detecting fraud in federal, state, or county-funded programs offered by the Alliance. Health care fraud includes, but is not limited to, the making of intentional false statements, misrepresentations or deliberate omissions of material facts from any record, bill, claim or any other form for the purpose of obtaining payment, services, or any type of compensation for health care services for which you are not entitled.

The objective of the Alliance's Anti-Fraud Program is to identify and reduce costs caused by fraudulent activities and to protect members, healthcare providers and others in the delivery of healthcare services.

The Alliance Compliance Officer and Compliance Committee oversee its Anti-Fraud Program and to manage suspected fraud and abuse reporting. The Alliance reports its fraud/abuse prevention activities and suspected fraud/abuse to regulatory and law enforcement agencies as required by law.

The Alliance requires its providers, members, contractors and sub-contractors to report incidents of fraud/abuse to the Alliance or the appropriate regulatory and law enforcement agencies.

Under no circumstances will the reporting of any such information or possible impropriety serve as a basis for any retaliatory actions to be taken against any individual making the report. No Alliance employee, provider, contractor or member who reports suspected misconduct will be retaliated against or otherwise disciplined by the Alliance or any Alliance employee for making such a report in good faith.

How to Report Potential Fraud, Waste, and Abuse

To report an incident, please contact:

Alliance Compliance Department
Toll-Free Hotline: **1.855.747.2234**
Email: **compliance@alamedaalliance.org**

Medi-Cal Fraud and Abuse
Toll-Free: **1.800.822.6222**
Email: **stopmedicalfraud@dhcs.ca.gov**
Medicare Fraud and Abuse
Toll-Free: **1.877.772.3379**

Medicare or Medi-Cal Fraud, Office of Inspector General
Toll-Free: **1.800.447.8477**